U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM

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ORAL HISTORY WITH RADM (ret.) JAMES A. JOHNSON, JR., MC, USN

CONDUCTED BY

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SYNOPSIS

Rear Adm. James A. Johnson was born in Wilmington, N.C. and grew up in Chicago, IL. His father, James Johnson, Sr., had served in the Army in World War II and later worked in postal service; his mother, Avis Ruth Payne Johnson, was from a prominent family of educators based in Chicago. Johnson's maternal grandmother was a pioneering Latin teacher; Johnson's aunt (mother's sister) was the legendary journalist Ethel Payne, the second African American woman to serve in the White House Press Corps,.

Although born in Wilmington, North Carolina during his father's tour of duty there, Johnson relocated with his mother to Chicago soon after his birth. In this oral history, Admiral Johnson details his early life in Chicago, describes the neighborhoods, community, and educational system in great detail and discusses his family's expectations for his future life. As he explains, his family had three overarching rules that he would follow in his life — Rule one: You will go to college; Rule 2: You can be whatever you want to be, but whatever you choose, you must strive to be the best at it. Mediocrity is not on your list of options. And rule 3, whatever you decide to do in life you must approach it with honesty and integrity.

One of Rear Adm. Johnson's distinctions from his early years was his role as a Congressional Page. In 1959, Rear Admiral Johnson made history when he was selected for the prestigious Congressional Page Program; he was the first African American page to serve in the House of Representatives. His time in the program ultimately led to his attending Oberlin College in Oberlin, Ohio.

Rear Admiral James A. Johnson earned his undergraduate degree in Biology/Chemistry at Oberlin College and went on to obtain his Medical Degree at the University of Rochester in Rochester, N.Y. He served both his internship and residency at the University of California at Los Angeles. He was commissioned in the Ensign 1915 Program in 1966. His early assignments included serving as the Senior Medical Officer aboard the amphibious assault ship USS *New Orleans* during the waning years of the Vietnam War and as a General Medical Officer at Marine Corps Recruit Depot, San Diego, Calif.

In 1975, Rear Admiral Johnson left the Navy. After completing his internship and residency at the University of California at Los Angeles, and private practice, he returned to the Navy in 1983.

During a subsequent assignment to Naval Hospital Camp Pendleton in California, Rear Admiral Johnson held a progression of assignments including Staff Surgeon; Chairman, Department of Surgery; and Director of Surgical Services. Rear Adm. Johnson was next assigned to Naval Hospital San Diego as Assistant Chairman, Department of Surgery. In 1989, he was transferred to Washington, D.C., where he held the position of Deputy Chief of the Medical Corps. Upon transfer to San Diego in July 1991, he was assigned as Medical Director at Naval Hospital San Diego and was subsequently named Deputy Commander, a position he held until February 1994. During his next assignment, he assumed command of Fleet Hospital SIX which deployed on a United Nations mission in Croatia. In October 1994, he became the Commanding Officer of Naval Hospital Bremerton, Wash., where he served until August

1997. He was then selected as the Principal Director for Clinical and Program Policy in the Office of the Assistant Secretary of Defense for Health Affairs. In August 1998, Rear Admiral Johnson was reassigned as Medical Officer of the Marine Corps at Headquarters, U.S. Marine Corps Washington, D.C. He supported the mission of Navy Medicine as the Medical Officer for the Marine Corps by maintaining liaison between the Navy Surgeon General and the Commandant of the Marine Corps. He advised the Commandant of the Marine Corps headquarters staff agencies on all matters affecting medical and dental support for the Marine Corps. In October 2001, he assumed command of Naval Medical Center San Diego and became Lead Agent, TRICARE Region Nine. In his final assignment, Rear Adm. Johnson assumed his duties as the Regional Director of TRICARE Regional Office-West (TRO-West) in November 2003, the first of three Regional Directors to be named, overseeing health care contracts and the health care delivery system in twenty states with more than 2,000,000 TRICARE eligible beneficiaries. Rear Adm. Johnson retired in 2004.

Rear Adm. Johnson earned certificates from the American Board of Surgery and the American Board of Medical Management. He also served as an Assistant Clinical Professor of Surgery at the Uniformed Services University of Health Sciences. His affiliation with civilian medical organizations included his status as a Fellow of the American College of Surgeons. He was also a member of the American Medical Association, National Medical Association, American College of Physician Executives, Association of Military Surgeons of the United States, and the Society of Medical Consultants to the Armed Forces. His military decorations include the Defense Superior

Service Medal, Legion of Merit, Meritorious Service Medal, Navy and Marine Corps Commendation Medal, Joint Meritorious Unit Citation, Navy Meritorious Unit Citation, National Defense Service Medal, Vietnam Service Medal, Armed Forces Service Medal, Humanitarian Service Medal, Philippine Presidential Unit Citation, United Nations Medal (Yugoslavia), the NATO Medal, and the Vietnam Campaign Medal.

KEY TERMS AND ACRONYMS

48th Air Force Transportable Hospital

212th Mobile Army Surgical Hospital

ACMC—Assistant Commandant of the Marine Corps

Armed Forces Physicians Appointment and Residency Consideration Program or Berry Plan

Balkan Crisis

Brown vs. the Board of Education of Topeka, 1954

CPHP—Clinical Pathway-Healthcare Professional Program

FRSS—Forward Resuscitative Surgical System

Iowa Gun Turret Explosion, 19 April 1989

MCRD—Marine Corps Recruit Depot

Naval Hospital Bremerton, WA

Naval Hospital Camp Pendleton, CA

Naval Medical Center San Diego, CA

Newport News Explosion, 1 October 1972

Operation End Sweep

Page Program, House of Representatives

Subic Bay, The Philippines

TMO—The Medical Officer of the Marine Corps

U.S. Navy Fleet Hospital No 6, Camp Pleso, Zagreb, Croatia

USS *Kitty Hawk* (CV-63)

USS *New Orleans* (LPH-11)

USS *Newport News* (CA-148)

USTRANSCOMM—U.S. Transportation Command

KEY FIGURES

Ashley, Ludlow

Ayres, William

Bohman, Harold, CAPT, MC, USN

Boorda, Jeremey Michael, ADM, USN

Brooks, Ernest, HMCS, USN

Burkhart, Thomas, RADM, MC, USN

Byrd, Robert

Clark, Vern, ADM, USN

Covey, Dana, CAPT, MC, USN

Diaz, Alberto, RADM, MC, USN

Diggs, Charlie

Fussell, Maceo Eugene “Gene,” RADM, MC, USNR

Hagen, Donald, VADM, MC, USN

Halder, Robert, RADM, MC, USN

Higgins, Robert, RADM, MC, USN

Holsted, William

Johnson, Bernett “Bernie,” CAPT, MC, USN

Johnson, James Avery

Jones, James, Gen, USMC

Koenig, Harold, VADM, MC, USN

Krulak, Victor, Gen, USMC

Lehman, John F.

Longmire, William, Jr.

MacKenzie, Donna

Mattis, James, Gen, USMC

Mayo, Richard, RADM, MC, USN

McDaniel, William, RADM, MC, USN

McGee, Frank

Mencik, Barbara, CAPT, MC, USN

Mosher, Charles

Moss, Arthur

O'Hara, Barrett

Payne, Avid Ruth

Payne, Ethel

Potter, Bonnie, RADM, MC, USN

Powell, Adam Clayton

Rayburn, Samuel

Ridenour, Richard, RADM, MC, USN

Roosevelt, Frank

Sabiston, David

Schwartz, Seymour

Stennis, John

Vinson, Carl

Zimble, James, VADM, MC, USN

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Problems with Shipboard Drugs and Alcohol

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Recruiting Marines Years Immediately Following the Draft

Surgical Residency at UCLA

Returning to the Navy

Navy Medicine in the 1980s

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Operation Provide Promise

Command of Naval Hospital Bremerton, WA

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Inspection of Bremerton's Subordinate Commands

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The Medical Officer of the Marine Corps

SESSION 1: 29 October 2018

The date is October 29th, 2018. Today we have the great privilege of speaking with Rear Admiral James Johnson of the Medical Corps. Today we'll be looking back over the course of his prestigious medical career and four decades of service in the U.S. Navy. This session is being conducted as part of the BUMED Oral History Project.

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Birth in Wilmington and Father's Army Service in World War II

Again, Admiral, I really appreciate your time today. Thanks for being part of this project. As with all of these sessions, we always like to start off at the very beginning, and I know you have a very interesting past and I'm wondering if you can talk a little bit about where you were born and where you grew up first?

I was born in Wilmington, North Carolina, and the reason I was born in Wilmington was because my father, who was in the Army, was stationed there. So I began my life as a military brat, so to speak. I was born in June 1944, a few days after the Normandy Invasion, and I was born at a time when there was still a draft. In 1944, the draft was relatively new and had existed in our country for less than ten years. My father was among the first Americans to be drafted.

My dad was stationed at an Army base that was just outside of Wilmington and not too far from Camp Lejeune. In fact, years later when I was at Camp Lejeune, I went and visited this tactical training area that the Marines used for tanks. Amongst the grass and the bushes and whatnot, you could see asphalt and remnants of the old camp. You

could envision the old barracks there back in 1944. On the road leading to Wilmington there is a historical marker commemorating the fact that this tactical area had once served as an Army camp.

Back then, the military was segregated, so this was what would be described as an "all-Negro base." When the war was over, particularly after the military was de-segregated in 1948 by Truman, I'm sure there wasn't a need for a lot of bases like that. First, there wasn't a need because the war was over and we didn't have those numbers of people in service, and second this was a segregated military base and the Negro bases didn't have the kinds of services that other bases did. My father's camp was, I'm sure, mainly barracks and whatnot for training.

Again, there were probably not the funds nor the social interest to equip a Negro base the same way you did a Caucasian base. So my mother lived in the area and I was born in a hospital in Wilmington.

So you were born in a civilian hospital?

Correct, because one: I doubt that there was any kind of military facility like that on this date when I was born. And two: I suspect that there was nothing for dependents on the base. If you think about some of the historical movies like the *Tuskegee Airmen*[1] or *A Soldier Story*[2] think about the way the bases were depicted. There were no dependents around and there was no commissary. There weren't a lot of facilities.

[1] A 1995 film starring Laurence Fishburne depicting the story of the pioneering Tuskegee Airmen, the first all-African-American Army Air Force Squadron.

[2] A 1984 film set on an Army base in Louisiana about the murder of black drill sergeant at the end of World War II. The film starred Howard Rollins and Adolph Caeser.

These movies were centered around what was going on with the Negro troops at that time. My guess is that a lot of these support services did not exist back then, which is why my mother lived off-base somewhere and there wasn't an alternative option. And my dad, when he got a little extra time, would go visit her.

That must have been tough on your mom. Did she ever talk about that period in North Carolina?

Interestingly no. She didn't, and of course that was back in the days when segregation was not only present but legal. I know that she wanted to go back home as soon as possible. One of the reasons why it took six weeks to get back home was it took her that long to rise high enough in the priority list to be able to get on a train to Chicago.

Not long after I was born my dad was sent overseas. And probably within a week after he was sent away, my mother wanted to take me back to Chicago because that's where her family was. I was about six weeks old when we left North Carolina. I should say my mother[3] was born and raised in Chicago, and my dad[4] was born and raised in Trenton, Tennessee, which at that time was a rural community northeast of Memphis. We didn't have any family in North Carolina.

Where did your father deploy?

My dad shipped to Asia and he worked the docks in India. He was in the Quartermaster Corps and like many World War II veterans he never talked much about

[3] Payne, Avis Ruth (1917-2005)
[4] Johnson, James Avery (1913-1971)

his experiences with family members. My wife's father was a Marine and it was very similar—neither she nor her brother or mother knew anything about his time in World War II, but he had lifelong Marine buddies and they talked about their service, but never shared it with their families.

So, my dad was sent to the docks of India where a lot of supplies and logistical stuff came in for the war. I believe at some point he was driving trucks on the Burma Road.[5] He didn't talk that much about it and what I'm relaying to you is what he mentioned to me after he realized that I was going to get orders to the war in Vietnam. My dad died in 1971 and we never learned his stories.

Long after my dad died I discovered in my mother's closet a mailing tube. Inside, and in mint condition, was my dad's "Crossing the Line" certificate from November 1944 with his name PFC James A. Johnson (I am James A. Johnson, Jr.). This certificate, which is in my office, is among my most cherished possessions.

[5] Ancient mountainous road that runs 717 miles from Burma (Myanmar) to southwest China.

Earliest Recollections

What were some of your earliest memories growing up?

I'm old enough to remember active segregation because I would travel to Tennessee and spend time with my dad's family.

What do you recall thinking as a child seeing those signs?

Well, it was obviously wrong. I grew up in a household where both of my parents espoused education. I come from a family with a lot of educators and education is the number one priority in my extended family. It is prized above anything else. As early as three or four years old I knew I was going to college. I could read when I was four, and that might sound pretty amazing, but not really because I was read to from the time I was born.

Do you have siblings?

I have one sibling who's eight years younger than me. He's also a physician-he's a pediatrician. He lives about a ten-minute walk from me. For much of my life we lived much farther apart.

You mentioned that college was always on the horizon, but what about medicine and science? Was there also a push towards medicine?

First of all I have to give you the extreme rules of my family. This is what I started hearing from my parents and extended family from the time I was three or four years old.

Rule number one: You weren't born stupid so you're going to college. So, "no college" is not an option. It's as much of a requirement in your life as breathing, and I learned that from before I went to kindergarten.

Rule number two: You can be whatever you want to be. You don't have to be what your parents want; you can be whatever you want to be. But whatever you choose, you must strive to be the best at it. Mediocrity is not on your list of options.

And rule number three is: Whatever you choose, you have to approach that and your life with honesty and integrity. Criminality is not on your list of options.

Did you ever stray from that path?

No. Straying is not one of your options. I mean, straying and swaying when you're dancing is okay (*laughter*) but it's not an option.

Where in Chicago did you grow up?

Originally Englewood and this was an interesting neighborhood. At that time Chicago, and it could be still the case today, was a city of neighborhoods. This was a nice, romantic way of saying it was the most segregated city in America. Each neighborhood is predominately black or white, and if it's white it's not just white, it's Italian, Irish, Polish, Greek, etc. In the Chicago of my youth there were churches everywhere. We went into the ethnic white neighborhoods and there was a Catholic church everywhere. And in Chicago, interestingly, some of the churches were only a few blocks apart; that's because the neighborhoods changed a few blocks apart.

I was raised on the 6200 block of Throop Street in Chicago. It's still there. That block was sort of a village. On that block there were some multi-story homes where each floor was a family house. So, if it's two stories the people living on the first floor are a different family from the people living on the second floor -kind of like the walk-ups in New York. On that particular block, there were three or four families that owned, probably, at least three-quarters of the buildings. My grandmother's[6] house, which was the centerpiece in our family was located at 6210 Throop Street. That dwelling still exists today. I lived directly across the street at 6215. We lived on the second floor. I had two aunts who lived on the block. My uncle-these are all maternal-lived two and a half blocks away. I had another aunt, who was a pioneering journalist, so she lived in Washington, DC, but traveled a lot.

What was her name?

Ethel Payne.[7] The post office released a commemorative stamp of her years ago. She was one of the pioneering black women in journalism-either the first or second African-American woman in the White House Press Corps.

My other aunt was the one who really broke the mold and lived apart from the village. She was six blocks away. And on that same block were the Stokes. They had a very similar situation where Mrs. Stokes was equivalent to my grandmother and some of her children lived down the street on the same block. The Hamptons were another

[6] Payne, Bessie.

[7] Payne, Ethel (1911-1991). Known as the "First Lady of the Black Press," Payne was a columnist and lecturer who was one of the first black journalist to serve in the White House Press Corps. In 2002, Payne was honored with her own Postage Stamp as part of the "Women in Journalism" series.

family who had several dwellings like that. So, on this block-even though it was an urban area-it was very much what I would call rural and southern. My maternal grandmother had been born in Kentucky and raised in Evanston, Indiana. People forget that culturally many African-Americans who lived in northern cities came from the south. Many of them, like my father, moved there after the war. So, while you might live in Chicago or New York or whatnot, your culture was southern. I was raised in a southern culture; I was raised on southern food. Delicious, but not healthy. My dad died of a sudden heart attack in 1971. My dad started every day of his life that I can remember with bacon, eggs cooked in bacon grease, and grits. That's what he was raised on. He was never overweight; he was always very active, but he had a heart attack at 54 and died.

On Chicago Schools and Segregation

Chicago, of course, is laid out on a grid, and so if you're going west every six blocks you hit a major street, usually somebody's name. But streets that were on a north/south configuration all had names, but the south side of Chicago is somebody's name. Streets that run east-west all had numbers. And so, the street immediately to the north of 62nd Street was 61st, about every fourth street was a relatively major thoroughfare in which you would expect to find buses, etc. So there were bus routes on 63rd Street and 59th Street. So Chicago's laid out that way, which also makes it relatively easy to draw school districts and what not.

For whatever reason, Loomis, which is the street that is two blocks west of Throop, and Racine, which is two blocks east of Throop Street, are major thoroughfares. Racine was where the school district was drawn for Englewood High School, which was a very predominately black high school since forever because the neighborhood it encompassed was 90 percent black. For whatever reason, between Racine and Loomis when you crossed 63rd Street, the neighborhood changed to all white. It was Englewood. The El[8] ended at Loomis and ran between 63rd and 64th Streets. When you crossed 63rd Street and got on the other side of the elevated El tracks the neighborhood became mostly white. There was a park there called Ogden Park, which was interesting because to the north and east of the park there were still predominately black areas. Southwest of the park were predominately white. And interestingly enough, both races used the park. Negroes—and I use this term "Negro" because that's what was used when I was a kid. Everybody says black now, but I say African-American. That wasn't part of the language for anybody back then—the Negroes tended to use the facilities that were in the east part of the park, and whites used the facilities that were in the west. There was no mixing. And I would never in a million years think of exiting that park through one of the western exits. They were putting in all white neighborhoods back then. Not a good idea.

But the reason why I'm going through this is because there was this little expanse of what amounted to a black area that somehow was in Lindbloom's High

[8] Elevated Train

School[9] district, which was predominately white. Just this one little area that would include four to six blocks of black families that were in Lindbloom's High School district. And of course, back in that day-not like now-there were no school buses. If you were getting anywhere you walked or you got on Chicago Transit Authority or whatever. So, my mother and all of her sisters graduated from Lindbloom, and they walked to Lindbloom High School, which was a couple miles from where they lived everyday through what was an all-white neighborhood. There were things that were understood. I never heard of any of them being attacked or beaten up or anything like that. There was an understanding that there was this little village, if you will, that was part of Lindbloom's area. And so if you were walking to school nobody bothered you. But if you showed up at six o'clock in the evening that was a different story.

My father's brother worked at Corn Products Refining Company, which was located on the southwest corner of Chicago, and a little bit south of Cicero, in Argo, Illinois. This was a big factory that took all the corn from the Midwest and turned it into starch and syrup. It took corn in one end and out the other end came all these different products. The area where the factory was located was not any place that a black person wanted to be after dark. But again, there was sort of a code, and my uncle would take the bus out there and nobody would bother him. It was clear that the reason you were on that bus was to go from the black neighborhood to Corn Products where you had a job. Nobody ever got off that bus at any stop other than back home or at Corn

[9] Robert Lindbloom Technical High School (now known as the Robert Lindbloom Math and Science Academy).

Products, and you were only on the bus during certain hours when shifts would change. So again, if you saw a bunch of black men on the bus at six or seven o'clock in the morning there was no reason for alarm because they were going to Corn Products-they weren't going anyplace else.

When you asked me how I felt about the south, I experienced the same things in the north. The difference between the segregation in Chicago and segregation in Tennessee is that there were no signs. When I first went to Tennessee, I remember seeing "Colored Only" signs for bathrooms, drinking fountains, everything.

The Illinois Central Railroad started in Chicago and ended in New Orleans; it sort of runs along the Mississippi River when it gets to the south. Their main train—called the *City of New Orleans*—left from Chicago every day to travel south. It was a full-service train with sleeping cars and all that. I remember being put on the train when I was about eight or nine years old, and sent down to spend some time with my paternal family in Tennessee. When the train was in Illinois you could sit anywhere. I'm sure that if you sat next to a strange Caucasian woman and started to put your arm around her it wouldn't end well for you, but assuming that you followed the unwritten rules, there was not a problem. Somewhere in Kentucky, the composition of the train was finalized, and when it crossed the Kentucky/Tennessee border, all the cars became segregated. So the car that I was in originally had some white people in it, by the time it got to Tennessee, there were only black people in that car because Tennessee was segregated.

And I remember Trenton (TN) had a movie theater and everybody who was Negro sat in the balcony. On the first floor was a regular movie theater with regular movie theater seats, etc., etc. The balcony had wooden benches and no seats. It was an open area with very primitive wooden benches. There was no such thing as eating in a restaurant. There were some restaurants in which you could get to the counter through the back door. There was no walking in the front door. If you wanted to get takeout in a few restaurants, maybe you sort of slipped your order into somebody and they handed you a bag between trash cans and what not.

It was the world that I lived in until Brown vs. Board of Education[10] changed it in 1954. I spent the first ten years of my life in an environment that was openly segregated everywhere, including Chicago.

From an early age I was taught that discrimination and segregation were morally wrong and wrong in every way. I was told that the world is not a fair place and that whatever you wanted to do you were going to have to work at least twice as hard with fewer opportunities than any of your white counterparts; that much would be given to them, but you would have to earn everything you got. Nothing was going to be given to you. You would have to earn everything you got, and even when you did that there would be those that would work less hard as you worked and get way more.

Although your profession could be taken from you, your education, your learning, your knowledge could not be stolen from you. That was another reason my family were big proponents of education. And the other thing I was taught was that as unjust as it

[10] Brown vs. Board of Education of Topeka (1954) was a landmark Supreme Court case in which the justices ruled unanimously that racial segregation of children in public schools was unconstitutional.

was, as wrong as it was, you were never allowed to use that as an excuse for your failure. For my maternal grandmother who was very religious and spiritual, wasting an opportunity was an absolute mortal sin. She was extremely well educated and had been a Latin scholar. She was born in 1883 and went on to graduate high school at a time when so many of her contemporaries never got past the sixth grade. So in her era, earning a high school diploma was equivalent to having a college degree at Harvard. She was a Latin scholar and when her family moved to Chicago she would have been a teacher, but she was prevented from taking some of the exams that would allow her to become a teacher. And so she channeled that injury into her religion. She was very religious, and she became the superintendant of the Sunday School of our church, St. John's African Methodist Episcopal Church. We lived three doors from that church.

But as I said, education was always emphasized in my mother's family. My father's family was very rural, relatively uneducated compared to my mother's side. But my father did get a college degree at Tennessee State. He played varsity basketball and football. He was very bright. He came from a family of 13, I believe.

For me, to be born to parents—both of whom had college degrees—was also not typical for a child born in the 40s. My mother came from a family of six-three of whom had college degrees; the other three did not, but they were older for the most part. My mother was the youngest one. My mother graduated from what was then West Virginia State College,[11] which again, going away to school at what was a historically black

[11] Founded in 1891 as the West Virginia Colored Institute. After Brown vs. the Board of Education the school was desegregated. It is now known as West Virginia State University.

college. I think it's been renamed to something else now, but that's where she went to for her education. It was a very different time.

So what about your schooling? How did science and medicine end up on your radar?

When I was a child I had very bad asthma, and winter time was a bad time for me and I would get asthmatic attacks that landed me in the hospital. I had my last asthmatic attack when I was 11, but, as a younger child I was sick a lot. In addition to having every childhood disease-measles and all that stuff I spent a lot of time being sick and missed a lot of school being sick. But even when I wasn't in school I was still learning; work was brought home. I did very well in school. I decided to be a physician when I was six years old. So, when people asked me, "What do you want to be when you grow up?" I would always reply, "I want to be a doctor."

I don't know why I said that, but I decided to be a doctor when I was six. Looking back, I think it was sort of Freudian, because of all of the time I spent being sick. I was also very attached to my pediatrician and I remember she was a very positive role model. I didn't grow up to be a pediatrician, but I believe that's when the seed was planted, and, of course, I was sick so much I saw her a lot. My parents had medical books on the shelves when I was growing up, and I remember reading them when I was eight, nine, or ten years old. So, the seed got planted early.

You must have stood out among your friends and peers, I would think.

I would say most of my peers, except for two, were just normal kids. When I graduated from middle school in the eighth grade, there was a group of us who were what would now be called the "brainiacs." I mean, I skipped a year of elementary school. I had a cousin who was two years older than me and she skipped two years of elementary school. She graduated from high school when she just turned 16. In fact, at the time she actually graduated from high school she might have been short of her 16th birthday. She went on to study at Wellesley. My Aunt Thelma was one of the first [Negro] principals of an elementary school in Chicago. My mother was a social worker and did a lot. My grandmother was a leader in her church and did a lot. Women had more opportunities than black men as long as they stuck to fields like education and whatnot.

My dad was very smart, but after World War II, if you were a Negro male you had to find something steady. And of course, he had a child and so he went to work at the Post Office. One of the reasons why the Post Office is so heavily populated back in the 40s and 50s by Negro men is because that's where they could find jobs. And so while the Post Office had a lot of "blue collar" and lower level "white collar" jobs, many of the Negroes who were in those jobs were like my dad-highly educated, but that's the only kind of steady job they could get to support their families. Working at the post office you knew you were going to get paid on whatever date-you could count on it. And upward mobility was possible in the Post Office.

When he came back from the war, my dad wanted to go back to school and get his master's degree, and be a physical education teacher. He was an excellent athlete. I

still have some of the papers he wrote. He wrote a thesis in college on the history of Negro churches in America. But he made a conscious decision, and I think subverted some of his own desires in order to raise me. And after further review after he died, I also figured out my dad had what we now call PTSD, which many men had coming back from World War II.

And it was something that was never addressed.

We had the VFW and American Legion and all those kinds of organizations. My father didn't drink, but the guys came back and they went to their local American Legion, VFW post and tried to "heal" each other. And you didn't share what went on over there with your families. That didn't happen.

Did he ever keep a diary or a journal?

One of the things I discovered are some of the letters he wrote to my mother. At some point I got to read those, there may be some history in that. I remember a scrapbook of photos from his Army days, most of which were taken at the camp in North Carolina, but there was very little written. There's almost no written history on my father's side. There's a lot on my mother's side and I've been able to trace my lineage back to the early 1800's. But on my father's side, I can't because everything was oral. Remember, he came from a poorly educated rural family of 13. Neither of his parents had a high school diploma. His father's state of literacy was probably marginal. When I went down to Tennessee to see my father's side it was a world of difference in terms of

education from my mother's side. And my father didn't spend a lot of time with his own siblings. His interactions, predominately, were with my mother's family.

I'd like to talk a little bit about your educational pursuits after high school.

You need to understand something about my elementary and high school-they are very important to my decision making for college and medical school, etc. Again, growing up in a segregated Chicago, we moved from where we were living across from my grandmother when I was eight years old when my mother became pregnant with my brother, and the decision was made that we needed more room and a better place to live. And two of her sisters who lived on the same block also made the decision that they wanted to realize the American dream of a detached family house, a bungalow, like big, white families in Chicago had.

Chicago neighborhoods would change when the real estate people decided to change the neighborhood. It was a conscious decision. They would sell homes to a couple black families and one of two things would happen-that black family would be run out of the neighborhood, or the neighborhoods would change from white to black. If the neighborhood changed from white to black, economically that was good for a lot of people. It allowed middle-class blacks like my parents and her sisters to move into a better neighborhood and into better housing. In other words, you couldn't buy homes like this in a black neighborhood, so it gave you an opportunity to buy a nicer home. For the white people it gave them an opportunity to make money. They could sell their homes at great prices. So, if the neighborhood was "changing," and if the real estate agents would fan that flame, they'd fan the flame of white flight. Neighborhoods would

change in a couple of years. We had been the first black family on my block, 7339 Indiana Avenue. My aunts lived on the next street over on 7300 Prairie Avenue and they were the first blacks on that block. Within two years, those blocks were 90 percent black and the new divide, if you will, became 75th Street. Although no homes were sold to blacks south of 75th Street, all the homes north of 75th Street that were being sold changed within two years. That's important because school districts were drawn along neighborhoods and as the neighborhood would change they would redraw the district so that the school district changed. The elementary school I should have gone to in my neighborhood was Ruggles, which was three or four blocks from my house. When we moved in and the neighborhood changed, they changed the dividing line of the school district to 75th Street. So instead of walking three and a half blocks to Ruggles, which is the district the neighborhood used to be in, I walked a mile and a half to Park Manor, which was all black. And rather than change the district they actually built a new elementary school in what was now the black neighborhood. That's how things were done then. Eventually I went to a new elementary school that was three to four blocks from my house, and it was a mixed bag-mostly black kids, but within that group there were blue-collar families and families like mine. The majority of people on our block did not have college degrees, but they were hard-working middle-class families.

In my eighth grade class, there were three of us who wanted to be doctors-myself, John Sullivan, who eventually became a math teacher, and John Fleming, whose parents were doctors and he did become a doctor. When I went to Parker High School, which was the high school that my neighborhood was in, the Chicago school

system developed this honor's track, if you will, which was made for brainiacs-we took different courses-what we would now call AP. That was put in to satisfy families like mine that had smart kids who wanted to know why they couldn't go to better high schools. So, my freshman year at Parker, I was there with other very smart, black kids who took what would now be AP courses.

Becoming the First Black Congressional Page

Remembering that education is number one in my family. My aunt [Ethel Payne], who I said was a pioneering black journalist based in Washington, worked for the *Chicago Defender* and other black newspapers. She was very politically connected. When then Vice President Nixon visited Africa in the mid-50s, she was in the Press Corps that went with him, and that was a remarkable trip. She got to know Nixon and actually invited him to her apartment in Washington for a reception in his honor, which he and Pat Nixon attended back in, I think it was, 1956.

But you have to understand the magnitude of that. It was a significant social event, but also very intimate. The Vice President was coming at her request. It's hard to describe what it would mean for the Vice President of the United States to come to the apartment of a correspondent.

My aunt was politically very progressive. Famously, she had asked Eisenhower a question about civil rights that Ike didn't want to answer and didn't answer. I think it was a period of months before she was called upon again in the Press Room.

If you look at any movie depicting the House and the Senate, you'll notice that there are high school-aged boys sitting in the front, they're called pages.[12] That program doesn't exist now, but it did then. And, of course, education is very important to my family. One of the things that my aunt discovered is that all those pages would go the Capitol Page School. Pages went to school from 6:30 to 10:30 in the morning and for the rest of the day they worked in the House or the Senate or the Supreme Court. The Capitol Page School was a public school; it was a part of the District of Columbia Public School System, but in order to attend it, they had a very interesting requirement—you had to be a full-time employee of the House, the Senate, or the Supreme Court. So while it was funded by the District of Columbia Public School System, the Capitol Page School was essentially a prep school and all of the teachers were college professors. Why is that? Because they went to school from 6:30 to 10:30 in the morning, by 11:00, all students went to work and the professors would be able to double dip by working at the local colleges and universities like Georgetown. For them it was a pretty good deal because they could teach in high school for four hours and then in the afternoon could teach college courses. It was pretty lucrative for our teachers, and it was a good education for us.

The school itself was physically located on the top floor of the Library of Congress (Jefferson Building). If you go to the Library of Congress, way at the top on

[12] House of Representatives Page Program was in operation from as early as 1827 to 2011. The program was run under the office of the Clerk of the House. Pages were typically high school juniors who act as non-partisan federal employees providing administrative support to House operations in Washington, DC and the U.S. Capitol. The Page Program was cut at the recommendation of Speaker of the House John Boehner in 2011.

the building you'll see what looks to be an array of windows, but there are rooms and office spaces up there. That's where the Capitol Page School was. So, to my knowledge, we were the only high school students in America whose school library was the Library of Congress.

So in the middle of my sophomore year in high school I moved to Washington and went there for two and a half years and graduated from the Capitol Page School. Lyndon Johnson was the keynote speaker at our high school graduation.

What a typical day was like? Any stories of certain congressmen?

Oh yes, absolutely, because my story has some historical significance. At the time that I got the appointment, Barrett O'Hara,[13] was the congressman who represented my district in Chicago. O'Hara's district originally was an Irish-Italian-Polish south side demographic, if you will. Remember, I said the neighborhoods change. We moved to Park Manor when I was eight years old in 1952. By the time the mid-50s rolled around the neighborhood had changed, I remember going to see Martin Luther King in '56, '57 speak at a rally near my house.

O'Hara was not going to run for re-election in 1960 because in eight years from '52 to 1959 the neighborhood had basically gone from being Irish-Polish to ninety percent black. So, O'Hara was going to retire. I remember he was an old as Methuselah-chain smoker, his fingers were all yellow from smoking. He was the last of his breed, so to speak.

[13] O'Hara, Barrett (1882-1969), Representative (D) from Illinois serve in the House from 1953 to 1969. He was the last Spanish-American War veteran to serve in Congress.

So, he appointed me to be a page. It turns out that there had never been any Negro pages in the House. There were two in the Supreme Court, but there had never been any in the House or the Senate, so I was going to be the first Negro page in Congress and that was publicized. When I got to Washington everything was set up for me to get that appointment at the Capitol Page School in what would have been the second semester of my sophomore year, in January of 1959. When I got there, lo and behold, there was no appointment. It disappeared somehow and the assumption at the time was that one of the southerners decided that this appointment wasn't something they wanted. I mean, I remember when Carl Vinson[14] and John Stennis[15] were in Congress and not yet names of aircraft carriers. Sam Rayburn[16] was the Speaker of the House when I was there as a page. There was only one House office building and that was where they all there were. Hawaii wasn't a state yet. So, this was the backdrop of 1959 when I came to Washington, DC and it was becoming a big story. I remember going on the *Today Show* and being interviewed by Frank McGee.[17] What's going to happen when Johnson is in Washington?

It turns out the Southerners weren't to blame, but rather there was a problem with the Chicago delegation. Apparently, O'Hara hadn't satisfied some political thing, but the southern democrats were taking the heat for it. That never came out in any newspaper

[14] Vinson, Carl (1883-1981). Vinson represented his state of George in the House of Representatives from 1914 to 1965. During his time in office, Vinson was known to be a champion of national defense and a big proponent of the Navy and Marine Corps.

[15] Stennis, John (1901-1995). Senator from Mississippi who served in the Senate from 1947 to 1987.

[16] Rayburn, Samuel (1882-1961). Represented the 4th District of Texas from 1913 to 1961. Served 17 years as the Speaker of the House.

[17] McGee, Frank (1921-1974). Television journalist who worked for NBC from the 1950s until his death in 1974. Served as co-host of the Today Show with Barbara Walters from 1971 to 1974.

and it was never publicized. At the time, all I was interested in was going to the school. So while this was going on I actually had to enroll in Western High School because I'd been out of school for a couple weeks at this point. D.C. schools had four tracks-they had honors, college prep, some sort of average, regular track, and vocational. Western High School was maybe 50/50 white-black, and when I enrolled they automatically put me in Track Three, which is where most of the black kids were. There were maybe a couple in college prep, nobody in the honor's group. On the first day of class there was a math test and the teacher said, "I don't expect you to do well on this because you hadn't been in the class and I can see how far behind you are." I got 100 percent on the test because it was easy and I'd been on the brainiac track back in Chicago. So the bottom line is I had been put into the track with all the white kids and I aced the first test there. I'm not bragging, I'm just saying it was the level of preparation that I had between being in the brainiac group at Parker and then all the stuff I learned at home from my teachers-my aunts and uncles.

How did the issue with your appointment get fixed?

Eventually what happened was James Roosevelt,[18] the son of Franklin Roosevelt, got involved. He was a congressman from Los Angeles who represented a district that was changing. With some of the urging of Sam Rayburn, who figured out a way to bail the south out, Roosevelt said he would "bail me out." Remember, I said the requirement for going to the Page School was you had to be a full-time employee of the

[18] Roosevelt, James (1911-1991). Eldest son of Franklin and Eleanor Roosevelt, James Roosevelt would serve with distinction in the Marine Corps in World War II before entering politics. He represented California's 26th District from 1955 to 1965.

House or the Senate or the Supreme Court. Roosevelt got together with four members of Congress— Martha Griffiths[19] from Michigan, Quentin Burdick[20] from North Dakota, Byron Johnson[21] from Colorado, and William H. Ayres[22] from Akron, Ohio-so four democrats and one Republican. Notice that the five people that ultimately stepped up were bipartisan? None of them were from Chicago, and none of them were from the South. Each of them put me on their payroll for one day a week and created the position of "office page." I worked in their offices one day a week. While it was a part-time position, by working for each one of them five days a week was a full-time equivalent. So the five part-time positions equaled a full-time equivalent, which made me eligible to go to the Page School.

Over the course of the two-and-a-half years I was there, based on elections and what not, and after Congressmen Burdick[23] switched to the Senate, I also worked in the Senate office for a little while where members came and went. I worked for a total of 11 members of Congress over the two-and-a-half years I was there-ten Democrats, and one Republican. Ayres, the Republican, was the person I worked for the entire time I was there, interestingly. I worked for Ludlow Ashley[24] from Toledo, Ohio, Charlie

[19] Griffiths, Martha (1912-2003). Represented Michigan's 17th District from 1955 to 1974.
[20] Burdick, Quentin (1908-1992). Represented North Dakota's District At Large from 1959 to 1960. Later served as senator from 1960 to1992.
[21] Johnson, Byron (1917-2000). Represented Colorado's 2nd District from 1959 to 1961.
[22] Ayres, William (1916-2000). Represented Ohio's 14th District from 1951 to 1971.
[23] Byrd, Robert (1917-2000). Represented West Virginia's 6th District from 1953 to 1959. Later represented West Virginia in the Senate from 1959 to 2010.
[24] Ashley, Ludlow (1923-2010). Represented Ohio's 9th District from 1955 to 1981

Diggs[25] of Michigan and spent some time on Adam Clayton Powell's[26] payroll. I always had five offices at a time and that made me eligible to go to the Page School.

Graduation and Oberlin College

For the second half of my sophomore year and all of my junior and senior years I was at the Page School, which gave me a great preparation for college. After all, it was a prep school education. When I applied to college, I applied to the University of Illinois, which was my "go-to" school. I also interviewed at Oberlin and Howard, and then at Harvard and Yale, but I actually didn't like either one of them. I also could have gotten a Naval Academy appointment, but at that time if you went to the Naval Academy you were going to be a line officer. There was no track for becoming doctors. Remember, I said I wanted to be a doctor. And while I liked the idea of going to the Naval Academy, being a doctor won out. Long story short, I got into Oberlin.

I had graduated number four in my class, did well on my SATs, and played basketball (The only sport the Page School had was basketball and I played on the basketball team). At any rate, I got into Oberlin, which was highly thought of by my family. Remember, I came from a family of educators. While nobody had gone there they were very much aware of Oberlin's reputation as the first co-ed college and the first college to admit Negroes. And this was the school I really wanted to go to even though

[25] Diggs, Charlie (1922-1998). First African American to be elected to the House from Michigan. Represented Michigan's 13th District from 1955 to 1980.

[26] Powell, Adam Clayton, Jr. (1908-1972). First person of African-American descent elected to the House from New York. Powell was a Baptist minister-turned politician. From 1945 to 1971, he represented New York's 16th, 18th and 22nd Districts.

I'd never visited the campus. But once I got in I realized that I couldn't afford it. It cost too much, so I decided I was going to go to the University of Illinois.

One day, while I was talking to Congressman Ayres, I said, "I got into Oberlin, but I think I'm going back home to Illinois." And of course, as an Ohio congressman he was very familiar with the school.

He said, "Oberlin's a great school. Why don't you go there?"

I said, "I can't afford it. They didn't offer me a scholarship and my parents don't have the money to pay the ride to go to Oberlin."

He said, "There's another alternative." He walked me down the hallway to Congressman Mosher's[27] office. Mosher was also a congressman from Ohio. His hometown was Oberlin, Ohio, and he was also a graduate of Oberlin College. A couple phone calls were made and a week later I had a letter from Oberlin announcing that I had a scholarship and that they would loan me money and that I had a part-time school job. So, I went to Oberlin instead of the University of Illinois.

University of Rochester School of Medicine

Oberlin prepared me to be competitive for medical school and to get into the University of Rochester School of Medicine. Rochester is private, not cheap, but I got accepted. I had intended to go to the University of Illinois because that's what I could

[27] Mosher, Charles (1906-1984). Represented Ohio's 13th District from 1961 to1977.

afford. I had gotten married and was thinking about my family, but I decided on Rochester because they gave me a scholarship and gave my wife a job.

My internship advisor at Rochester was Seymour Schwartz,[28] the editor of one of the two major textbooks of surgery. I did research at Rochester in myocardial physiology and my sponsor was Art Moss,[29] a cardiologist.

I graduated with distinction in research from Rochester.

Internship at UCLA and the Surgery Specialty

On a day in late April, almost May, my junior year in medical school, Dr. Schwartz called me into his office and said, "Where do you want to go for your internship?"

I said, "I don't know. What are my options?"

He said, "Well, your record looks pretty decent, and looks like you're going to graduate with distinction in research." Rochester was one of the few schools that gave honors in research. I was getting one with distinction in research because of the research I'd done in myocardial physiology for Dr. Moss. And he said, "With your record and my recommendation you could go almost anywhere."

I said, "I want to go where there's no snow on the ground."

He said, "Florida or California?"

[28] Schwartz, Seymour. One of the most prolific and honored surgeons in American history; also a renowned author and cartographic historian.

[29] Moss, Arthur J., (1932-2018). A celebrated cardiologist best known for his work in understanding and diagnosing heart arrhythmias and preventing sudden cardiac arrest.

"I don't know, I've never been to either place. But what I can see of the pictures I don't think I'm going to like Florida with its bugs and swamps."

"Okay, then California. North or South?"

I interviewed at UCLA, USC, San Francisco General and also at the University of Colorado-obviously it snowed there but they had a very good program at Denver General, and the University of Chicago.

I ended up going to UCLA as a resident in surgery. UCLA had one of the best general surgery training programs—it was the "Johns Hopkins of the West" and headed by Dr. William Longmire.[30] Dr. Longmire was from Oklahoma but trained at Hopkins and when he started the program at UCLA he based it entirely on the Johns Hopkins model.

I was one of 14 interns at the time. Of the 14, three were from Rochester and three were from Oklahoma. I was the first African-American in the general surgery program there.

Why did you decide on surgery?

Interestingly enough, when I started medical school I was always interested in doing something extra because at Oberlin I was a bio/chem major and I did an honor's project in behavioral genetics. So for whatever reason I got interested in research, got hooked up with Art Moss who had his own research lab, and he was interested in myocardial oxygenation. Long story short, the experimental model was canine hearts, so in order to do the experiment and set up the physiological equivalent, it required doing open-heart surgery on the dogs. But in order to do the measurements and the

[30] Longmire, William, Jr., MD. (1913-2003). Founding chairman of surgery and founding father at UCLA.

various things going on, you had to isolate the dog's heart and dissect out the coronary artery. The main coronary arteries and the coronary sinuses, in order to put oxygen measuring probes. Each experimental model required about an hour to an hour and a half of surgery to prepare them. Moss had his own technicians, but eventually, I learned how to do that and without realizing developed a lot of surgical techniques and interest.

I also worked as the diener my sophomore year in medical school. The diener is the person who prepares autopsies with pathologists. On TV, the medical examiner is typically seen preparing his own autopsies. In the real world that often doesn't happen. Usually it's a technician who does all that stuff and the medical examiner then comes in and examines the work of the technicians. And that was my sophomore year. So I spent a lot of time—often at two o'clock in the morning—preparing a deceased for autopsy—opening the chest, dissecting out all the organs, running the bowels, taking the brain, all that sort of stuff. I then started my clinical rotations during my junior year.

At the time I determined that I wanted to be a cardiologist. And my first rotation in my junior year and clinical years was in internal medicine at Northside, one of the affiliated hospitals. After that two-month rotation in internal medicine I loved it. What I loved was being on call because whenever you got away from University Hospital there were less layers and you got to do more. In the late 60s, the "house staff" and students were doing a lot of the stuff. Doctors would come in, but it's like when I was a diener, pathologists would come in after all the preliminary stuff had been done. Doctors would come in on emergencies when you had done all of the preliminary stuff unlike what you see on television now. At two o'clock in the morning there wasn't an attending

[physician] there. It was all run by house staff. There was no sense having fully trained doctors that were running emergency rooms. That didn't exist in the late 60s. There's a reason why people were called house staff, because we were in the house staffing things.

I always liked action. I liked doing stuff. The second rotation was on general surgery, and that two months was an epiphany for me. The only house staff whose names I remember from my medical school days are the chief residents from general surgery. They were like gods. They could do everything that the smartest internist I ever met could do. And they went to the operating room and operated. And in that two months I came in contact with people who were brilliant operators and I decided that's what I wanted to do. In fact, at the time I decided I wanted to be a heart surgeon. And remember, back then when you came in to prepare for surgery, the surgery was scheduled, the interns and students were there at six in the morning. Number one: people didn't come to the hospital like they do now. Everything is done as an outpatient. You show up at six in the morning and an hour and a half later you're in the OR. Back in the late 60s, if you were having an elective operation, you were admitted to the hospital no later than the day before-sometimes two or three days before. They have all these tests they can do as out-patient, all these blood tests and X-rays-it was all done as in-patient. If you were having a big operation, blood was drawn the morning of, the Foley catheter was put into the bladder-there were all these things that were done and that was all done by the interns and the students on the ward before you went to pre-OP. So, on surgery there are all kinds of things that nowadays are either done by the

doctors themselves, or more likely by “technicians.” So, if you have blood drawn a phlebotomist now comes along and does that. Somebody gets paid to draw blood. People who drew blood back then were the students. People who put in the catheters were interns and students. So, on general surgery, it’s part of the normal course of being a student. You had a lot of responsibility for doing things that nowadays are done by technicians. I probably put in more IVs as a medical student on surgery than a typical medical student would do in his entire career now because that’s just how things have changed.

I never really thought about surgery because I didn’t realize that my working as a diener and my research had given me a lot of technical skills that I hadn’t realized when I got on surgery I was ahead of my typical peers. I remember one of the surgeons said to me, “Why do you want to be an internist? Why don’t you want to be a surgeon?” And by the time I finished that surgery rotation, I decided I really wanted to be a surgeon.

Frankly, I hadn’t processed it. Until I got on surgery, I didn’t realize what surgery was about. But my clinical rotation in Rochester gave me insight into what surgery was really about, with people who said you can be a part of this.

SESSION 2: 12 November 2018

Ensign 1915 Program

When I was a freshman in medical school in 1966 I signed up for the Navy Ensign 1915 Program, which was the forerunner of the HPSP scholarship program. There was no HPSP when I was in medical school. This was the time of the draft. My father said to me, “You don’t want to go into the Army.” He had nothing good to say about his Army experience. It was a very different time-there was a war and segregation. He had a brother who was in the Navy. Now the Navy itself doesn’t have a pristine history regarding race. In fact, up until, and I think including World War II, Negroes primarily were used when there was a war and in between wars they were all let go and served as stewards. And remember, there was only the Army and the Navy then-there was no Air Force. There was the Army Air Corps, but it was the Army and the Navy. The Army is a service that had a continuous role for Negroes between wars; albeit segregated and what not. But it wasn’t like the Navy that jettisoned Negroes after wars. But, my father said, “If you’re in the Navy there’s better food.” His brother’s experience being on a Navy ship in World War II wasn’t great either, but that’s what he said.

I grew up watching *Victory at Sea*, I made a lot of airplane and ship models, but for some reason I’d never been on the ocean. It wasn’t like I had some maritime tradition in my family that just didn’t exist. But I read books on John Paul Jones and sea voyages and there was a romantic notion about the sea service. So, I was a senior in

Oberlin I went to my local draft board and I said, “What are the chances of my being drafted while I’m in medical school?” That was my fundamental question.

They said, “If you’re going to medical school,” and I’d already been accepted, “You go into a different pool.” The pools for Selective Service are sort of regional, so Chicago might be one region, downstate was another, but at any rate, the pool was sort of regionalized. For doctors it was a statewide pool. Illinois had a quota; Indiana had a quota. So I said, “So what are the chances of my being drafted and serving if I’m a doctor?”

He said, “Unless you’re missing an arm and a leg the chances are 100 percent that you’ll be drafted into the Army.”

The Navy had this Ensign 1915 Program, which the main attraction means a guarantee that I would go into the Navy as opposed to the Army. I signed up for it in early 1966. Back then, the benefit of being in the Ensign 1915 Program was you were still eligible to apply for the Berry Plan,[31] meaning you wouldn’t have to come in until you finished your residency. The other ways they could access you was right after your internship, or any time during your residency. And, if you wanted a military internship, the Ensign 1915 Program gave you higher preference.

So, they called me up in my internship year and they said I would be coming in not after I finished my internship, but the year after I would get, basically, two years of

[31] Armed Forces Physicians Appointment and Residency Consideration Program (or Berry Plan). Conceived in 1954 by Assistant Secretary of Defense for Health Affairs Frank B. Berry (1892-1976), the Berry Plan allowed for physicians to be deferred from military service while pursuing training in medical specialties that they would use in their two-year military commitment. The adoption of the all-volunteer military force in 1973 marked the end of the Berry Plan.

surgical training and then I would go into the Navy for two years on active duty; two years in the ready reserve, and two years on the standby reserve. People forget that Selective Service commitment was a six-years-two years active, four years on the reserve. So, the commitment to the military was six years under Selective Service.

Unlike most doctors who accept a commission directly as a lieutenant, I was commissioned as an ensign. In my junior year of medical school, I was promoted to lieutenant junior grade, and I graduated medical school as a lieutenant. Nowadays you have the scholarship program where all the scholarship students are ensigns when they're doing their rotations on active duty. None of that existed back in 1966 when I came onboard. So, that's why I got into the military, I was commissioned in 1966, and I never got out. In 1972, I came in on active duty. I left in 1974, went back to my residency and then private practice. And remember, after we ended the draft it took them awhile to alter the reserves so the bottom line was when I decided to go back into the military in '83 it turned out my reserve commission was still active and they never had taken me off the roles. So, back in '83 it was a relatively simple, "recall to active duty process."

SMO Aboard USS New Orleans

What do you recall about those first experiences in the Navy?

The first thing I recall is when I got my orders. I was in the beginning of my second year of residency at UCLA, so somewhere around 1971. I had been sent, what they called, a "dream sheet" where you could put down your preferences. It had shore duty and sea duty. At the time, I thought that, "Gee, I'd like to stay close to Los Angeles." The closest naval hospital to Los Angeles was at Long Beach and there was one in Camp Pendleton and in San Diego. So I went to the hospital at Long Beach, talked to the Chief of Surgery there, and he said, "It would be great if you were assigned here. When we get you, you'll have had two years of your surgical residency. Assigned to the department, I could use you a lot here, even if you were a GMO." So I put down Naval Hospital Long Beach as my first choice followed by the Naval Hospital Camp Pendleton, then the Naval Hospital at San Diego. You could sort of see the pattern. The closest hospital to Los Angeles, the next closest hospital, and so on. I get my orders maybe February or March, and they read, "You've been assigned to New Orleans." I called up the detailer and I said, "Why are you sending me to New Orleans? I want to stay in California." The detailer said, "Son, do the letters 'USS' have any meaning for you whatsoever?" He said, "Not New Orleans the city, *New Orleans* the ship. USS *New Orleans*,[32] which is home-ported in San Diego. So what are you complaining about?"

I said, "Well ok, but don't ships go places?"

[32] USS *New Orleans* (LPH-11). An *Iwo Jima*-class amphibious assault ship. She was in commissioned from November 1968 to October 1998.

He said, “Yes, but *New Orleans* is coming out of an extended yard period at Long Beach in April so the first year she’ll probably just be sailing around, doing local Ops close to San Diego, not much else.”

I get my orders to the USS *New Orleans*. Now keep in mind, I spent all my time up to that point in my life being inland. I’d been around water, like the Great Lakes, but I’d never been on the ocean. I’d never been on any kind of ocean going craft whatsoever. I get to San Diego along with 70 other new accessions from a variety of programs, Ensign 1915s, draftees, Berry Planners, the full gamut. We all arrived in Coronado for two weeks of orientation in July 1972. Then we all go off to whatever our orders said. The orientation was light on physical stuff, it was mainly teaching a bunch of guys who didn’t know much about the military, about the military. Like when you’re wearing your whites, you don’t wear your collar devices and shoulder boards at the same time, that kind of stuff. Two weeks of all that, dawn ‘til dusk orientation to the Navy. As soon as this was over, we each were going to our permanent duty stations. I remember that first Friday, the class was divided in half. Half of us went to the *Kitty Hawk* and half went to the *New Orleans* for a ship tour and to see what a ship was like. Obviously, I was in the *New Orleans* group. The *New Orleans* was tied up down at 32nd Street. We get on board we’re in the boardroom. The XO comes down and greets us and gives us a 5 or 10 minute, “Welcome to the Navy” speech. Then he says, “Is Lieutenant Johnson here?” I raised my hand up, and then he says, “Come with me, you don’t need to take the tour.” I followed him, we go down to his office and he sits me down and he says, “Well, welcome aboard.” I said, “Thank you, sir.” He was a Captain,

and had been a helicopter pilot. *New Orleans* was an LPH-11 which is a helicopter carrier. It only had a single screw, which was a bad design but McNamara[33] saved money that way. And two, although it had a complete deck for landing aircraft, helicopters, it had no well deck like LPDs. So all of it's assets were aviation assets. So anyway, he says, "What do you know about this ship?"

I said, "I've been told by the detailer that you came out of the yards in April and that you would be doing some local OPS to get the ship sort of shaken down from it's long yard period."

He said, "Ahh, yes and no. Yes, we will be doing some things at sea, but no we won't be local." This was a Friday at about two o'clock in the afternoon. He said, "The ship is leaving on Monday."

I said, "Where's it going?"

He said, "Gulf of Tonkin. Are you familiar with that?

I said, "Gulf of Tonkin, isn't that somewhere near Vietnam?"

He said, "Very good, you're a quick study. I know that's a little short notice for you. So here's what you need to do. You need to go out and buy a sea trunk and anything that you want to be on that ship with you, you need to have in that trunk and be onboard the ship by 21:00 Sunday night. The ships leaving early Monday morning." He said, "You have to finish your orientation, finish the second week. We know that. So here are your orders. You're going to graduate a week from today. Then a week from

[33] McNamara, Robert (1916-2009). Secretary of Defense from 1961 to 1968.

tomorrow morning you're going to get on an airplane and you're going to fly to Hawaii. Then the ship's helicopter will pick you up. We're not stopping in Hawaii, but we'll be in range of Hawaii. A week from tomorrow we'll pick you up."

That's how I got introduced into the Navy and sure enough I got on a Western Airlines, champagne flight on Saturday morning, flew to Hawaii. I was met by a captain who took me to Hickam Field where I sat for about an hour and a half-two hours and then this double rotor, gray egg beater, came tearing out of the sky, called the "Cajun Queen." They threw the mail off, they threw me on. Then we flew for about an hour and a half and landed me on this platform that never stopped moving. That's how I got on my ship. This would turn out to be about a 10 to 11 month deployment.

I started my first year in the Navy was almost entirely at sea for which I had a two week preparation.

What were your first impressions of the ship?

My first impression of the ship was that it never stopped moving. I'd never been on the ocean and I have to admit there was a reason why they called the Western Airlines at that time the "champagne flight" because they served a lot of champagne. The flight wasn't very crowded and I was in uniform, along with another friend. The two of us were flying to Hawaii to pick up our ships. His ship was coming back from deployment so he was getting on a ship and he only had about five or six days at sea and then he was back home. When you're in uniform it's hard to hide the fact that you're in the military. You know, we're in the back of the plane, and the stewardess—they were called stewardesses back in '72—said, "Where you going?"

I said, “I’m going to Vietnam and he’s going to pick up his ship.” She said, “Oh, you poor dear, have some champagne on us.”

By the time I got to Hawaii, I was pretty hammered. After the flight to Hawaii, the heat, being under the weather and after the alcohol I got put on this egg beater for about an hour and a half and then landed on this platform that would never stop moving. I was righteously sick. We got to the ship at about 18:00 and the first thing they said was, it was time for evening chow. That was the last thing in the world that I wanted anybody to tell me. I said, “Nah, I’m not really hungry.” Long story short, I went to my rack and laid down and woke up the next morning. My Senior Chief who became a life-long friend knocked on my door and said, “Well, sir, the men are all down waiting for you to have some opening words.” Deployments were different back then. The Marines didn’t cross over with you like they do now. The Marines were all on Okinawa, so the amphibious ships that were going to be a part of the amphibious ready group made the transition to Asia from the U.S. mainland with few Marines on board. You picked up the main body of Marines in Okinawa. When the ship was fully loaded it would hold about 1,800-2,000 men; the ships company was about 500. On the transit over, there was lots of room because the Marines weren’t on board. You spent that two to three week transit time finishing up work to get ready for deployment. It’s now Sunday morning, I’m hung over as hell, I’m still on this platform that doesn’t stop ever moving. I go down to the sick bay that has maybe nine or ten corpsmen that are part of the ships company. The Senior Chief has got them all lined up. He was a grizzled veteran. It was his third war. He was from West Texas, and lied about age and came into the Navy at 16 or 17 in

World War II. He had World War II, Korea, and now Vietnam under his belt, more than 25 years in. He was as salty as you could get. Apparently, the guy I was relieving was, I don't even remember his name, but let's just say he wasn't really a combat kind of guy. The Senior Chief lines the guys up and gives me this introduction as "Two years of surgery residency at UCLA, fine training program. He's going to be with us the entire deployment. We're going to go into the war zone with a really good medical officer." There's about five minutes of this before he says, "I'm sure Lieutenant Johnson would like to say a few words to you." I opened up my mouth and projectile vomited on two of my corpsmen. Never got a word out. That was my introduction to my crew.

Oh my goodness, did they give you a nickname after that?

No. This was the old Navy, the relationship between the enlisted and the officer was very precise.

They carried me back to my bunk. I stayed there another 24 hours and then I was okay. Wouldn't be that sick again ever in my life. But you know, you can imagine, they're just saying, "Oh my god, this guy. . ."

Sounds like it did not bode well for this cruise.

Let's just say I got off to a shaky relationship. The importance of it was I felt tremendous burden or motivation that I had to always do the right thing with respect, not only to my patients, but to my crew. I literally sat at the feet of my Senior Chief and he taught me everything that I needed to know about being a naval officer. He was always very respectful and always called me "doctor"—he never called me Jim or anything like

that. But he, like all good Chiefs with a fresh caught Ensign or Lieutenant, you have to teach them how to be a naval officer, no matter what their background is; even if they went through Annapolis, they still have to be taught. He taught me how to be a naval officer as we transitioned across the Pacific. I listened to everything he said. He said things like, “You’re a lieutenant, and you’ve been in the Navy less than a month. You are the Senior Medical Officer on board this ship. When the surgical teams come on board, there will be some officers and doctors that will outrank you. There will be captains, commanders, fully trained surgeons as part of the surgical teams [*The surgical teams also didn’t cross over. They were flown over and got on board like the Marines. Surgical teams served for three months. They would come from some hospital, Camp Pendleton, Long Beach, Philadelphia, wherever. There would be three months of TAD, they’d fly them over and they’d spend three months on the ship and then they’d fly back to whatever hospital they were from*.]

On board the *New Orleans*, because I was a department head, I had my own state room. There was a plaque over it that said, “Ship’s Medical Officer.” The Senior Chief taught me what a billet meant—it meant that if you’re in this billet you have all the responsibilities and authority of that billet, irrespective of your rank. The ship’s medical officer could be a lieutenant, could be a captain, could be a commander, it could be anyone. But whoever was the ship’s medical officer has the direct authority of the Captain of the ship, surgical teams are temporary so therefore there are things you can order people to do. So even though the head of the surgical team might be a commander or a captain, administratively, you are their boss. That didn’t seem like

that's going to work very well. He said, "It'll work just fine, because you and I will make it work." He taught me things like, you have the number one responsibility for making sure the Captain of the ship and the Commodore—because we were the flagship of the whole taskforce—are "good to go." So somewhere, somehow, you have to find a way to get time with the CO and the Commodore every single day we are under way. You have to go up on the bridge, you have to find some way to get in their presence and interact with them so you can determine whether or not they're good to go. Only you can do that. It can't be done, like, "Sir, come down, let me check you out." He said it can't be that kind of thing. You have to find a way to get in to see them stealthily to check them out. That kind of stuff.

At this point the *New Orleans* was the flagship of the taskforce, correct?

Absolutely. The standard Amphibious Ready Group at that time would be an LPH, a couple of LPDs, and a couple of LSTs. They were 5-ship ready groups. Amongst the taskforce you would have an entire battalion of Marines which included the aviation element, ground element, logistics, etc. This would have been one of the most medically capable ships in the Navy at the time, outside of a hospital ship. The design for that kind of capability started in the 60's, and ships like the *New Orleans* were designed to have far more capability than was required for the 500 in the ship's company. Aircraft carriers, including today's aircraft carriers, have a single operating room. *Iwo Jima*-class ships like *New Orleans* had two formal operating rooms, an 8-person ICU capability, an ICU and patient ward rooms.

What was the first mission of this taskforce?

As we crossed over we spent about a week at Subic. When we went to Subic we were picking up Marines who were about halfway through their deployment from Okinawa. At that time, this was now early August of 1972, the Philippines had just had a horrendous monsoon season and in the previous 30 days they'd had somewhere between 80 to 100 inches of rain. That entire country was flooded, literally the entire country was underwater. When you pulled into Subic, your medical capabilities are essentially shut down. You might do a little triage or a sick call on the ships company, but by and large your needs are minimal. It turned out that some Captain from the Amphibious Medical Group flew over and decided we were going to go on a MEDCAP.[34] Keep in mind now, I've been in the Navy maybe a month at this point, on active duty. So I didn't know what a MEDCAP was, but I found out. Basically, it's a humanitarian mission where you're going someplace to provide medical relief. It turns out that most of the jungle survival training happens in the Philippines. Members of the Negrito tribe were the principal instructors, they basically were the people who taught anyone who had to go through jungle survival training, whether they're pilots, special ops, whatever, how to survive in the jungle. When you get dropped in that situation for field training, you get dropped in some remote place with a knife and the clothes on your back and not much else and you've got to survive for a week. You've got to learn how to kill, eat snakes, what to do with water, the whole nine yards. These were the guys who

[34] MEDCAP (Medical Civic Action Program) type of operation designed to assist an area by using the capabilities and resources of a military force or civilian organization to conduct long-term programs or short-term projects.

were the instructors. It turns out that their home village was completely flooded out. We organized this humanitarian thing to go to their village and administer humanitarian aid. I don't think I'd been in the Philippines more than 24 hours before I was on a helicopter heading to the jungle. Which as it turns out was not entirely friendly because remnants of the communist insurgency was still going on.

We landed on kind of a sand bar in a flooded out area. I saw stuff I'd only read about. Cholera, TB, all kinds of stuff for somebody who trained in Southern California and upstate New York, only read about in books. All the weird sort of tropical ailments I had read about in books or heard about when I was half asleep during a lecture was now right in front of me. There were people coughing up blood, there was cholera, there was a whole gamut of stuff that I'd received shots for that we were treating. At some point there was some gunfire, the tribesmen grabbed their weapons and ran off into the jungle up to the mountains and had a fire fight with the insurgents. Keep in mind, I certainly found myself in a very austere environment, treating things that I thought I'd only ever see in books, and I was under fire and we hadn't even gotten to Vietnam.

You're one month into your active duty Navy career. What are you thinking at this point?

I'm thinking that maybe this wasn't the part they covered when I watching the *Victory at Sea* movies. So this mission lasted a couple of days and then we had to get back to Subic to take off.

You had mentioned some of these tropical ailments. Was the Navy fully equipped to treat these diseases?

Yes, in those situations if you do anything you've made things better. We introduced some antibiotics and stuff like that. The most important thing was leaving medical supplies behind that could be used by the indigenous tribes themselves. I don't know if guys who were stationed at Subic Naval Hospital[35] came up there or not.

Subic Bay and Olongapo

One thing I learned from repeated visits in Subic, and how do I put this politely, there was a significant cultural difference between the medical guys who were on ships, those attached to the Marines and the guys who were permanently based in Subic, at least at the time I was there. The guys who were permanently based at Subic were kind of elitists, I don't know what the right word is. The last thing they seemed to want to do was get involved with anything that had to do with these rag-tag ships that would come in. It wasn't their thing, you know. They were in whites a lot, I'll put it that way. Subic was one of the areas that you could wear shorts with your whites. So they had their shorts and nice little knee socks and of course, we fall in with our cammies or what not. There was a reason why sailors and Marines are the way they are, you'd go out on the line, it was all male, there was no women. You'd go out for 30, 60, 75 days on the line, you'd come back for five days in port. Olongapo was the adjoining city to the town of

[35] Naval Hospital Subic Bay, P.I., was in operation from 1956 to 1992.

Subic. Back then it was sort of like Dodge City or Deadwood. This is not hyperbole; this is the way it was in 1972. The streets weren't paved. There were strict rules about what Americans could do and not do. So if you crossed over into Olongapo you couldn't have any weapons, but the Filipinos could and they were armed to the teeth. There was a part of town that was maybe okay, but the liberty part was literally like Deadwood. There was bar after bar after bar. The bars were somewhat segregated because Filipinos were great at karaoke and lip syncing, and they would learn American music. You would go into one bar and it would be Janice Joplin and hard rock, another bar and would be country and western, while another bar would be the Supremes. They tended to learn a particular kind of American music. If you went into the bar and you closed your eyes you couldn't tell the difference between them and Aretha Franklin. But obviously the bars tended to be occupied by people who liked that particular kind of music. So you wouldn't find the brothers in a country & western bar at all. The bars established kind of a cultural divisiveness. Remember this was just after the 60s, things were pretty raw with respect to racial rights which I'll get into, and are a significant part of this deployment.

One thing that my Senior Chief always did on the first night whenever we got to a new port, some place I'd never been, was show me the ropes in every liberty town. So A, I wouldn't get in trouble, B, I would know firsthand all the places my Marines and sailors would get into trouble so I would know how to treat them when we left the port. Olongapo was probably the most challenging liberty port. It was also the port that sailors and Marines liked the most. Why is that? When you're out on the line you get combat pay and there's not much to spend your money on. Back then everyone smoked and

you could get cigarettes at sea. There were about 15 cents a pack, and a dollar or so for a carton. What are you going to spend your money on if you don't gamble? Cigarettes are cheap, food is free so you're piling up all this money and nothing to spend it on really. If you had family, they got their money through allotments. I sent virtually all of my regular pay back home to my wife and two kids and lived off just the money from what I earned over there. When they rolled into a port, a lot of sailors and Marines had all of this money in their pockets and Olongapo was very inexpensive. You could go to town in Olongapo with $20 in your pocket and have a great meal, drink as much as you wanted, and usually find companionship, I'll put it that way. You could pay for a room, wake up the next morning, and go back to the base with change in your pocket. Needless to say, it was very popular. It was very important to the Filipino economy. Two aircraft carriers would pull in and an Amphibious Ready Group you would run into a supply and demand problem. They would send out to the remote villages for an extra supply. It was huge. Now the other thing is, we pulled in, in August, like I said, it was like Deadwood. There were a lot of Filipino gangs, armed to the teeth. You could be walking around and there would be a shootout in the street, just like in the Wild West, between the rival gangs and whatnot. It was lawless, it was completely lawless. We left and we went off on our first line duty which lasted about 60-70 days. While we were gone between August and we came back in October I think. Marcos[36] took over the country and declared martial law and took everybody's guns away. When we came back to

[36] Marcos, Ferdinand (1917-1989). Served at the 10th president of the Philippines (1965-1986).

Subic the second time in October, it was very different. The gangs had most of their weapons taken away and it was much calmer. You could still do very well with $15-$20 in your pocket but the shootouts became a thing of the past, which was kind of nice. Whatever you thought about Marcos, at least the open shootouts went away.

Vietnam

In 1972, the war was winding down. In the fall of '72, Nixon was campaigning and wanted to get us out of Vietnam. Watergate had happened but nobody knew Watergate had happened. Watergate hadn't been discovered yet. But as far as the war was concerned, Nixon was working on getting the Vietnamese to the bargaining table. So the kind of combat operations in Vietnam, we were being less aggressive about being offensive. We were in a defensive holding pattern. So the mission for the Marines on board the ship was to go on an assault and take ground and then the Army and other Marine units who were in Vietnam would stabilize an area after the sea-born Marines had gone in. Because we were less offensive the number of missions in country were less. In fact we had a couple of missions where we would act as though we would launch an invasion from the sea primarily to get the Viet Cong to re-position their forces. That's the way that 60-65 days went.

One thing I did was treat a lot of STDs. In fact, at the time there was a resistant strain of gonorrhea which was literally epidemic amongst the sea-born folks. When we came out of Subic the first time I think I had somewhere between 100 to 200 guys—

sailors and Marines—lined up with STDs for sick call. Virtually all of them had gonorrhea. I gave everybody the standard treatment which was two grams of penicillin or something like that. You'd come in, you'd get a swab taken of your discharge, a gram of penicillin in each buttock and off you went. But my first time in I had a 40 percent failure rate. It didn't work. So then I gave them a second treatment of tetracycline, which was the first order of treatment for anybody who was allergic to penicillin. Tetracycline pretty much cured everybody. I cracked the code on the cause of the Penicillin-resistant strain. The reason why I did that is because my Senior Chief—who was an experienced guy who knew anything and everything about stuff that doesn't show up in any book or action report—had a network. The incidence of PID (pelvic inflammatory disease) and gonorrhea amongst the working girls is enormous. PID in females hurts; in outbreaks it's hard to do your job with a raging case of PID. You want to do your job because the number of sailors and Marines are huge. That might occur over a 10-day period and then they go back to sea and then it's quitter. Business is cyclical depending on how many ships are in port. A long story short, what I found out was that the girls were using an ointment to put in their vaginas which would mitigate these symptoms so they could keep turning tricks. The problem was it wasn't curing things, obviously. It was just killing the local stuff, the bugs mutated and created a resistant strain. I communicated that information to the elitists at the hospital, but I don't think they did anything with it because that resistant strain of gonorrhea from Southeast Asia was not quelled until several years later. The next time out at Subic, with scores of sailors and Marines in the sick call line with gonorrhea, I gave everybody the standard dose of penicillin and the

standard dose of tetracycline, the only two antibiotics I had on the deployment. When we gave them both, my failure rate dropped to two percent from 40 percent.

Communication on Deployment

Communication between your deploying forces and the shore forces was kind of hit and miss. There were requirements but does anybody read this stuff? Remember this is 1972, there was no Internet. Everything was hard copy. When you left for deployment your family didn't hear from you, there was no TV aboard the ship and there wasn't any email. It was a much bigger Navy, the Navy itself was three times the size of the Navy today, but the communication wasn't there. It was the draft era, the majority of people who were serving in the military had a 2-year obligation and they were getting out and they never wanted to look back. So you know it was a very different climate. People forget about that today when we've got this all volunteer force where even the weakest link is somebody who volunteered for it.

We had Berry planners, draftees, and others. Remember Vietnam was not like World War II where everybody was patriotic and would give up their lives wanting to be there. It was a very unpopular war, particular by the time we were there in the 70's. Whatever popularity, whatever bias the country ever had for Vietnam went away in 1968 with the Tet Offensive. Which by the way is a battle we won, overwhelmingly. The Tet Offensive in 1968 was an undeniable, overwhelming military victory for the United States and its allies. But the way it was depicted in the news and the footage getting footage of what was going on in virtual real time was all new. Now, CNN and Fox News

covers something five seconds after it happens. That's not the way it was back then. '68 was the first time Americans really got a near real time insight into war and the good, bad, and the ugly. A lot of the ugly is what came across like the footage of a policeman shooting a guy in the head right on the street.[37] Or the footage a little girl walking down a deserted street after having it Napalmed.[38] I remember that; it was shocking to Americans.

Remember that time frame was the tail end of the draft, it was also the tail end of being able to fight wars incommunicado. My dad and his generation never talked about what they did in World War II. My wife's father was a Marine and there was never any discussion. She never knew anything about what her dad did. He left sometime in 1942 so virtually every campaign in the Pacific that involved Marines he was involved in, but she nor anybody else in her family couldn't tell you squat about what went on. He went over there with his brother and some friends and they talked about it, they drank about it. They didn't talk about it with family members. My mother knew zip about anything that happened to my dad when he was overseas in the docks of India and working on the Burma Road. Even in my time if you communicated something you sent a letter, but that letter might take a week or two before it got delivered. I would write letters and I would write numbers on the outside of the letter, so this was "number 1," "number 2," etc. because the letters didn't necessarily arrive in sequence. It was harem scarem. If the

[37] Infamous Eddie Adams' photograph of South Vietnam's National Police Chief shooting an arrested Viet Cong member in the head on the streets of Saigon, February 1st, 1968.

[38] Photograph/footage of South Vietnamese napalm attack, taken on June 8, 1972.

wife got a letter which was “number 3” and she hadn’t gotten numbers “1” or “2” yet then she was supposed to wait until they showed up. Nowadays guys are on e-mail and Skype and all that in real time. Everything is instant. That’s not the way things were back then. That technology didn’t exist. So when I came back after that long deployment, I was like my dad, I didn’t talk. I had a different wife then, I didn’t talk to her about any of that stuff. Just didn’t do it.

How long was this deployment?

I left, got on that airplane in the third week of July and came back, it was mid-May, might have arrived the Friday before Mother’s Day in ’73. So 10 months. It was supposed to be shorter, our relief had broken down crossing over. Remember I said they only had one screw, she had to be towed into Subic and underwent repairs. We were extended at least three months because our relief had to have its shaft repaired.

The *Newport News* Explosion

On that first deployment there was an incident with the USS *Newport News*,[39] which was a heavy cruiser, had 8-inch guns. Remember the battleships, the *Missouri*-class battleships had 16-inch guns. Ships like the *Newport News* in the *Des Moines*-cruiser class had 8-inch guns. They had turrets as opposed to gun mounts. Most

[39] USS *Newport News* (CA-148) was a *Des Moines*-class heavy cruiser commissioned in January 1949 and decommissioned in June 1975. On 1 October 1972, while in action off the DMZ, *Newport News* sustained an in-bore explosion in her center 8-inch gun of number two turret. A defective auxiliary detonating fuze caused the projectile to detonate almost immediately upon firing. Nineteen men were killed and ten injured.

destroyers and ships like that have gun mounts; guns bolted to the deck of the ship, hence the term "mount." The turret is part of the infrastructure of the ship. The support for a turret goes all the way down to the keel. So the support for gun turrets, battleships and cruisers, that's actually put in as the ship is being built from the ground up, so to speak. It's like when you're building an office building, before you're even close to putting anything down, you're drilling down deep and you're putting down these re-bars and what not to go several stories into the ground. That's how turrets are fashioned on ships; a turret is part of the basic infrastructure of the ship. The *Des Moines*-class of cruisers were like many battleships. They had 8-inch guns as opposed to 16-inch. Their decks were teak wood, the same way they are on battleships and the reason for that is the recoil from those 8 and 16-inch guns was so great that if you just had ordinary decking the vibration would buckle the ship and would break the metal. So teak wood is what the decks were made of because they absorb the concussive effect of those big guns better than metal. The *Missouri*- class battleships also had teak wooden decks, which is ultimately the reason why they were decommissioned because the manpower it takes to keep those decks serviceable in incredible; it's very labor-intensive to take care of those decks. Deck departments are huge on battleships and old cruisers. So at any rate, if you remember there was a gun-turret explosion aboard USS *Iowa.*[40] The *Newport News* had a similar explosion in 1972. At the time they were providing fire support, I believe off of I Corps[41]; we patrolled mostly up in I Corps which was off of Da

[40] *Iowa* Gun Turret Explosion, USS. On 19 April 1989, the number two 16-inch gun turret aboard USS *Iowa* (BB-61) exploded killing 47 crewmen. Multiple investigations that followed offered conflicting conclusions.

[41] I Corps was the Corps of the U.S. Army headquartered at the Demilitarized Zone (DMZ) in Vietnam.

Nang and Quang Tri City, the area closest to the DMZ between North and South Vietnam. The Marines were in Da Nang and Quang Tri City and those places. The *Newport News* was providing fire support, something happened and their forward turret exploded similar to what happened aboard the *Iowa*. At the time our taskforce was less than an hour sail from them so we were first on the scene to provide aid to the *Newport News*. Obviously a whole bunch of people were killed outright. Then there were people who were injured fighting the fire, etc. We took their casualties on board and provided assistance because first, our medical capability was designed to take care of hundreds of casualties. Second, we had virtually unlimited aviation support because we were a helicopter carrier. Getting casualties off for us was relatively easy compared to if you had to send a bunch of small boats and get them transferred. It's daunting enough using aviation, but the ocean is the ocean and the ocean doesn't necessarily quiet itself just because you need it that way.

It was one of those situations where if you were really close you got killed, if you were further away there were less issues with the blast injury. At least one of those deaths was not from the blast, per se. Three or four people who came on board initially appeared to be okay, some minor injuries, no big blast injury. But then over the course of 24 hours they went into respiratory failure. I figured that there must be something that they had inhaled; I didn't know what it was. First thing I had to do was get more respirators. We had an aircraft carrier was about 100 miles farther out than we were. Long story short is we had to send to Subic and Okinawa to get a half a dozen more respirators. Which then had to be flown to the aircraft carrier by fixed wing, and then

heloed to our place. I later found out what caused it when I started reading about it. The composition of the powder bags is highly classified, but it turns out that one of the by-products after the explosion is nitrogen oxide which is a highly poisonous, odorless, colorless gas that causes respiratory failure over 24-36 hours after inhalation. When I determined that's what they had, the treatment for it was putting them on a respirator. I lost one on board the ship, I think I had at least three or four others that came down with it. We eventually got them to Subic which was another role of evolution. How do you get a guy to Subic who's on a respirator? You can't send him in-country. You can't off-load him in Da Nang, a big war going on there. You can't send them to the aircraft carrier. If you get them on the aircraft carrier how do they survive the ride on the airplane to get to Subic? They don't. We actually left theater of operation, sailed back to Subic, off-loaded these guys and then went back to the war. But I only lost one onboard the ship and I think eventually one other died from that. There may be half a dozen guys who got it, basically saved most of them. Again, this is the kind of stuff you don't read about. It certainly wasn't covered in the two weeks of orientation. This is the kind of stuff you figure out because your Senior Chief has the kind of relationship with the senior gunner's mate, he chief-to-chief explained it. Then the gunner's mate decided I had a need to know and therefore showed me the classified information on the composition of the powder of the 8-inch guns.

Race Relations at Sea

Admiral, you were serving at sea during a period of time when race relations in the Navy were at a low point. What was the experience like aboard the *New Orleans*?

Race relations back then were not good. I think it was the fall of '72 when the incident aboard the *Kitty Hawk*[42] took place. The situation aboard the *Kitty Hawk* got a lot of publicity. What most people don't know about is that *Kitty Hawk* situation occurred in other taskforces, including ours.

So we went out, came back into Subic, and changed Marines. At the end of our first line period, the Marines we had on board were done with their six-month tour. During that interval the ship went through Subic to Okinawa, and then came back to Subic. I actually got permission during that time to fly to Japan to meet my wife for a week on R&R before coming back to the Gulf of Tonkin with a new set of Marines, and a new surgical team. The Marine unit we took from Okinawa were having *Kitty Hawk*-like problems in Okinawa. When they came on board and we went out to the Gulf of Tonkin this continued. It also involved ship's company. There was a night where there was literally a race riot on board the *New Orleans* and a couple of other ships and the guys would run up and down the passageways assaulting each other. It was ugly. This is on the line. Aircraft carriers were maybe a couple hundred miles away, nobody attacks them. Any flight that came from the Vietnamese mainland that didn't have a U.S.

[42] USS *Kitty Hawk* (CV-63) was an aircraft carrier in commission from April 1961 to May 2009. On 12 October 1972, the *Kitty Hawk* was en route to her station in the Gulf of Tonkin when a race riot involving more than 200 sailors broke out. Over 50 sailors were injured in this high publicized incident.

allied transponder on it was assumed to be an enemy navy's so it was shot down. There was a line of many aircraft cruisers and destroyers that was the first line of defense. Then there were the aviation assets so the chances of anything getting to an aircraft carrier was minimal. I mean, 200 miles out you wouldn't survive the gauntlet to get there. But Amphibious Ready Groups are different. Their mission is to launch assault troops so you're operating on the line, three to eight miles off the shore; and you could actually see the war going on over there. We would send people in for recon and every now and then a helicopter would come back with a few bullet holes in it. At any rate, on board guys were assaulting each other at two o'clock in the morning. Really scary stuff. You may be only three to eight miles off the shore, but your destination ashore really sucked. In addition to which there were a bunch of sharks in the water. So the idea of, good, bad or indifferent, staying aboard this ship is really your only choice. As it turns out, I was a senior black officer in the taskforce. There was only one other black officer on the ship and he was an Ensign. The Captain designated me to be in charge of making this issue go away. He basically said, "You're job is to make sure this doesn't happen again tonight." No pressure. I mean my skipper was a helicopter pilot, he was an Annapolis grad, top of the line. He's a true blue Navy guy. I got all of the black sailors, including one of the ring leaders who was my lab tech; he was a real loser. It was his second tour. He had got in trouble back in New Jersey, or wherever he was from, and the judge said you can either go to jail or go back into the Navy. So he chose to go back into the Navy. He was a real thug and was instigating a lot of this. He made sure he that wasn't in a situation where he could get caught. He would stir up some

unsophisticated sailor from Mississippi and make him want to go do something while he'd be in the background. Not every sailor on board was street smart, but this guy was. This was back in the day when the black sailors had little secret handshakes and all this kind of crap. Anyway, I got them all together and said, "Here's the deal, we're five miles from Vietnam where there's a war going on. So if anybody thinks they want to get off this ship and go over there, have at it. But people are getting killed over there, so that's not a good idea. The last time we had swim call, Marines were stationed on the fan tail so they could shoot sharks that were in the area. If you want to jump off the ship the waters are not very hospitable. There's half a mile or more of ocean under you and it's full of sharks." I said, "Here's the deal. I've got a wife and two kids." My youngest kid was two months old when I left. "No matter what happens over here, I intend and plan on going back home. The only way for me to get home is aboard this ship, not swimming, not going to Vietnam. The only way to get home is this ship. So anybody who does anything to this ship or anybody who does anything to affect the operations of this ship, I don't care if you're black, white, it doesn't matter, they are my enemy because they are standing between me and going home to my wife and kids. Anybody who supports this ship that's going to get me back to my wife and kids is my friend. Do you understand? I am also a partially trained surgeon. I grew up in Chicago and I know what to do with my enemies. Forget about the fact that I'm a lieutenant and educated. I'm a Chicago-bred surgeon and I know what to do with my enemies. So you decide if you want to be my enemy or my friend. It's as simple as that." Then I walked out. There were a couple of smatterings the next night but not much. Within 48 hours a couple of

the ring leaders amongst the Marines and sailors—both black and white—were taken off the ship and sent to the brig back in Subic. The divisiveness and all that was still there, but the problem didn't re-surface, it was a cultural issue. But after that we didn't have anybody going up and down the ship fighting.

Shipboard Tropical Medicine

I learned a lot about parasites on that deployment. For some reason, as I was packing my sea trunk on that weekend before deployment I found this little monograph about parasitology and something told me to throw it in there. This turned out to be very important decision. Back in medical school you read about all of these parasites and see all of these funny looking worms in formaldehyde jars. It turns out that when you're in a place like Asia and stop in all these ports like Subic and Vietnam you begin to encounter these parasites. Sailors and the Marines would come back aboard ship and purge them when they were having bowel movements. Virtually every Asian parasite that I'd only seen in a jar or read about I encountered on that deployment. That monograph I had packed became my absolute Bible and I became a parasitologist because of that book. Marines and sailors would eat and drink anything. They would tell you that they didn't drink the water but they would frequent bars. You would ask them, "Did you go to a bar?"

"Yeah."

"What did you drink?"

"Whisky and soda."

“Was there any ice in it?”

“Well yeah, who wants to drink that shit warm?”

“Okay, there you go.” Ice cubes were the same as drinking water out of the rice paddies and taking a big swallow. I learned that if anybody had an abdominal problem at any time to get a white blood count on them. There is usually no more than one or two percent of the differential of white blood cells that are eosinophils. If they’re much above 10 percent, there’s really only two things that can cause that, one is leukemia which is really rare; I maybe saw one case of that in my entire professional career. The other cause is an intestinal parasite. So when you do a differential on a sailor who’s got abdominal pain and white blood count is 30 percent of his differential is eosinophils, you know that he’s got a parasite. You would have him swallow all-purpose antihelmetic potion, strain his stool for 24 hours and all kinds of little things would come out, sometimes multiple species.

I never wanted to be a venerealogist with penicillin-resistant gonorrhea. As a surgeon, I sure didn’t want to be a parasitologist, but I became pretty damn good at that before my time was over. It’s the adventure the Navy talks about.

Problems with Shipboard Drugs and Alcohol

From what I have read, this was a period of time when drugs and alcohol problems were rampant in the Navy. As the SMO, were there issues with drugs and alcohol that you had to address?

Drugs and alcohol were big issues in the Navy. Ultimately, I got the lab tech I talked about court-martialed for being a dealer. Ultimately, it was about three quarters of the way through the cruise.

My Senior Chief told me when I first sat down with him, "You know way more about medicine and doctoring than I'll ever know, but you don't know shit about being a sailor." That's what he told me. And I didn't. I learned how to be a naval officer from him and I developed these relationships with the ship's crew and Marines because of him. I remember there was a gunny sergeant who was part of the aviation squadron. He was having chest pain and went to the flight surgeon who blew him off. The Chief was examining him in the Chief's Mess and he said, "Doctor, I'd like you to examine this guy, he's not part of the ship's company but I think he's sicker than the flight surgeon thinks." Some flight surgeons, not all, can be mainly interested in the pilots, the fliers, keeping them up and running. They don't all care about the enlisted guys in their group. This was one of those kind of flight surgeons. He didn't want to be there, he would only do the minimum to take care of the officers and drank with them and all that. The enlisted guys were a pain in the ass to him and we only saw the aviation guys on our sick call because he would always be off getting flight hours or whatever. So I looked at the gunny and examined him, and did an EKG. The guy was having ischemic heart signs

right on his EKG. I said, “We’ve got to get you evacuated to Subic.” So we did, and he survived and everything went okay. But that word got back to the head of the Marines who wanted to know why his flight surgeon hadn’t picked that up. I got talking to him about that. Anyway, long story short, the flight surgeon got put on report and eventually got short-toured. I don’t know what happened to him, but nothing good. You don’t screw with Marines. For that Marine Battalion, I could do no wrong. I loved their leather flight jackets, those are prized. One of those appeared in my office about two days after that incident. I still have it. That was their way of expressing their gratitude, looking out for their guys. Those are the kind of things that are built on relationships and leadership.

Augmented Surgical Teams

You had mentioned earlier about the presence of the surgical team on board. What was your relationship like with this unit?

It depended on the unit. I had three different surgical teams over the course of my deployment. Two of whom went very well, and one of them was rather contentious. The head of the surgical team was either a senior commander or a captain, but he clearly had a lot more stripes than I did. He came on board and was strutting his stuff-he was the Frank Burns[43] type. He was in charge of everything. Surgical teams were not part of the ship’s company and their quarters were temporary. The surgical team officers were in state rooms of two or three to a room. One day the head of the surgical

[43] Maj. Frank Burns was a fictional surgeon in the novel, film and TV show, M*A*S*H. He is the chief antagonist of Capts. Hawkeye Pierce and John “Trapper” McIntire maintaining a dismissive attitude toward his better-trained colleagues, and blaming others for his own failures

team decided that he should have my room. On board the *New Orleans*, the Ship's Medical Officer and the Ship's Dental Officer were both part of the ship's company and each had state rooms next to each other. These are hard to come by, but if you occupied the billet whose name is on the door, that's your spot. If you don't occupy the billet, it's not your spot. He came on board feeling like he was the senior medical guy, and he was, in terms of rank, no question about it. He didn't care where I went but I was moving out of there. I said, "No, I don't think so. That's not the way I'd been told it works." I told my Senior Chief, and he takes a look at me and says, "Nope, you are the Ship's Medical Officer, that is your space. I don't care what he says, you're not leaving that space." It actually took the CO and XO of the ship to sit him down and explain to him how things worked when we were in the Gulf of Tonkin. To say the least, he was not happy about that and tried to give me a hard time. Eventually it had to work.

Word had gotten around that this guy was giving the Ship's Medical Officer a bad time. Now remember I bonded with my crew. I'd figure out how to treat my crew. I took care of the Marines. It turns out when that happens is they take care of you. His laundry kept disappearing or it came back not done very well. I said, "Maybe I can help you with that." We had stewards back then, of course the stewards knew what was going on; they just took it upon themselves to do something about it. When he started being nicer his laundry started showing up again. Again, they don't teach you that in orientation.

Have you ever thought what your career would have been like if you had been assigned to the Naval Hospital Long Beach as opposed to going to sea?

It would have been very different. I would have gone to a hospital with regular hours and taken call probably once a week doing something. My life would not be very different and I would never would have got to know the real Navy. I would have been in Long Beach or Pendleton and learned a few things and been home every night pretty much. I would never have an understanding of what it's like to be in the real Navy. I value the experiences I gained on my first tour; it taught me from the ground up.

Operation End Sweep[44]

In December in 1972, Nixon and Kissinger were engaged in negotiations with the Vietnamese about ending the war and getting our POW's back, including John McCain and others. The negotiations were going bad in the end. Vietnam was going badly. Nixon, over that December, launched this huge bombing raid over North Vietnam, bombed the bejesus out of Hanoi, Haiphong in particular, and dropped a bunch of mines on Haiphong, blockading their harbor. It forced the Vietnamese to come back to the table. In January, we were on a port visit in Singapore. We were there for two or three days when the visit was cut short and we were told to sail back to Subic. We went to Subic and we offloaded our Marines and if you've ever been to Subic, there's a big island—I think it's called Grand Island—offshore. When you're standing in Subic this big

[44] Operation Mine Sweep was a United States Navy and United States Marine Corps mission to remove naval mines from Haiphong harbor and other coastal and inland waterways in North Vietnam between February and July 1973.

island sits between you and the open ocean. Anyway, if you're on the other side you can't see what's going on. Long story short, we're off loaded all the Marines, we on loaded airborne mine sweeping helicopters. Once we unloaded them we took off and anchored up on the other side of the island and we were completely cut off, no communications what-so-ever was allowed. When we went into Subic we didn't talk to anybody about it. We had no idea what the hell we were doing and we weren't told either. As the Ship's Medical Officer you had duty to the commodore staff so I knew many things that other people didn't know. Carrying minesweepers was not in the playbook. Then we took off and it wasn't until we were on our way that everyone found out what the mission was—to take the taskforce to Haiphong, anchor outside the harbor, and then our sea-borne minesweepers and minesweeping helicopters would de-mine Haiphong. When the North Vietnamese were in negotiations with us they wanted their harbor cleaned up more than anything because it had been completely shut down. Haiphong, in my recollection, was kind of like San Diego; it was a finger of land kind of like Point Loma and a relatively short distance from the inner harbor to open sea, like San Diego. It's not like Norfolk where you've got a long river to go down before you actually get to the ocean. So if you put a bunch of mines in there you would lock the place down. That's what we were there for. At one point in negotiations broke down and I remember it was six o'clock in the morning, we went to general quarters. It was very foggy and basically we snuck the taskforce out of range and fog because the Vietnamese were balking. Negotiations went forward and they came back and finished

the job and the POW's were released. As far as I know that stayed a classified mission for some time. We certainly had no communication with anybody back home.

When we were done with that we went back to Subic and then we went home. On the long ride home, I took out a guy's appendix. The Ship's dentist was my anesthesiologist. I put in his spinal, the dentist monitored him, and I took out his appendix. There was no way to get him off the ship, we were out of range of anything.

While aboard the *New Orleans* did you take part in the Sky Lab recovery mission?

The ship had been designated to take part and when we came back and we immediately began training for the Sky Lab mission. I worked on that until I got off the ship, I think in July or August 1973. I was given a choice. I essentially did most of the preparation work for it. My choice was if I wanted to continue and actually do the mission, I'd have to stay on board that second year. At the time, I had orders to MCRD (Marine Corps Recruit Depot) in San Diego and MCRD doesn't go anywhere. I knew the *New Orleans* did so I decided that it was more important to be home than be in the South Pacific. Although the mission would have been exciting I already had a year of lifetime experiences aboard the ship. The experience I did not have was being with my kids. When I left my youngest son was a little bit bigger than a football, when I came back he was walking and talking and wanted to know who the hell I was. He thought my neighbor was his dad. As exciting as actually going on that mission was, somehow it didn't trump getting to know my kid.

Remembering Senior Chief Brooks

Your Senior Chief sounds like a very impactful figure in your career. Did you maintain contact with him in the years after your deployment?

Yes. Ernest Brooks[45] was from West Texas. He retired in 1973 when we were still deployed. I heard he came back to San Diego, had a wife and three daughters. He went into real estate here in San Diego and when I finished my residency in teaching at UCLA and moved here he got me my house. He eventually retired and left San Diego and moved to Oregon where one of his daughters lived. He lived there until developing Alzheimer's and then he went to the Rayburn Memorial Veterans Center in Bonham, Texas. The last time I saw Ernie was shortly before he died, he was in the home, his health failing and with Alzheimer's, he had good days and bad days. I had some business in Dallas and I decided that while there I would make a side trip so I drove up to Bonham. It was the peak of the summertime, I don't know if it was July or August, I just know it was beastly hot. I wore my blues to jog his memory and make sure he would know me and he did. I spent the day with him, took him out to lunch and had a good time. Now you've got to understand, this is Bonham, Texas; it didn't get more conservative, more military-oriented than Bonham, Texas. Although I was retired, I wore my 2-star Admiral uniform. When I walked in, let me tell you, that gets you a lot of attention in a place like that. People are lining up just to help you out. In fact, my only purpose for being there was to visit with Senior Chief and take him to lunch. That made

[45] Brooks, Ernest, HMCS, USN (1924-2006)

him a special person. Ernie Brooks was rural West Texan, he was 6'2" and he looked like the Marlboro Man. Which in Bonham, Texas, you know, was very much part of the demographic. Here I walk in as an African-American, with all this stuff on my uniform and there was Ernie. That elevated Ernie for the rest of his life. When I left they made it clear that they would always take good care of Ernie. I mean they knew Ernie was special but they didn't have any idea he was that special. How often does an 0-8 in any kind of uniform show up at that place specifically to see one person? He remembered me. I brought with me a belt buckle that had the New *Orleans* logo on it and I left it with him. I told the people, I said, "This is a belt buckle from the *New Orleans*, the last ship he was on. Every day, you make sure that this is the belt buckle he sees." It came to me that Ernie died when he was about 83 years old. From time to time, I talk to one of his daughters who lives near Waco, Texas. But Ernie was very important to me and he became a life-long friend.

The Marine Corps Recruit Depot

When did you start at the MCRD?

It must have been August 1973. I left at the end of June 1974 and then finished my residency at UCLA. So my tour to active duty at that time was basically two years—'72 to '74.

At MCRD I was one of at least half a dozen General Medical Officers. There was a guy in charge of the clinic, a Navy Captain. I forget his name, but he retired on active duty and spent most of his time fixing up his retirement home in Lakeside. We didn't see

much of him, which was good because he was kind of an asshole. Basically we ran the clinic, he'd come in, he'd be there by nine o'clock in the morning and he'd be gone by two in the afternoon, which was fine because he was worthless. It was myself and one of the other GMO's who had tours in Vietnam and we sort of ran the place. First of all, we were on a Marine base and we were the two doctors who had experience with Marines. We were there to help Marines change recruits into Marines. Like I said, we would get there early in the morning, the Corpsmen would screen everybody and then, a couple hundred guys would come to sick call. You had to strain and figure out the one or two guys that were really sick with something. That was your chore. Every day there was somebody who figured out that becoming a Marine was a bad decision on his part. They would try to find ways of getting out of it.

You can always tell the fresh caught recruits when you come in MCRD. These Marines would fly in or what not, and they would collect them. About eleven at night there'd be a bunch of long-haired, icky looking guys standing around, waiting for the bus, the Marines would pick them up and take them to the MCRD. They'd stand on the yellow footprints, which are still there to this day. At the stroke of midnight they'd start processing them. By six in the morning they would be recruits with no evidence of their prior life. Everything that was part of the prior life was stripped away from them. Everything they had would be issued to them by the Marines. They would receive their regulation cuts, which was like shearing sheep with these really sharp big clippers and it would take about four to six passes to give them a haircut. One on top, one on the side, one on the back, and maybe a couple to fine tune it and who'd be next? It would take

those barbers about 60 to 90 seconds for each one of them to get a haircut. They would literally be standing in hair up to their knees. Then they'd get issued their clothes. By sunrise they were back on the yellow footprints. Completely disoriented, without any sleep. The Marines would break down everything starting on the first night and over a course of weeks build them back up as Marines. Along the way, guys were getting legitimately sick. Shin splints and abdominal pains were common. You'd have to find out the one guy with abdominal pain once a week who had a tender side, nothing special. Corpsmen were very good. The Corpsmen would take 50 guys and screen them and maybe 10 of them would need to see the doctor. For every ten or so one would need to be kept overnight or sent up to Balboa for treatment. Of course there was some malingering. One kid came in saying, "I don't want to be here." I felt sorry for some of them if they'd made a bad decision, but it was not my job to get them out of it. If you did that then the next day you would have 30 guys in your sick call line. It would make it harder to find that one guy who wanted to be there but had appendicitis. You had to keep control of it. You don't want a situation where the people that needed treatment are lost amongst a bunch of guys who don't want to be there. But this one recruit threw himself down on the floor and started yelling and screaming, literally he had a 2-year old temper tantrum in the middle of my office. I ignored him. Next a private came in and looked at me and said, "What are you going to do about that?" The answer was nothing. "What's the matter with you, private?" I saw a succession of recruits and eventually when he saw I wasn't paying any attention to him he got up and said, "Okay, can I get out now?"

“Yeah, get out of my office? Yes. Get out of the Marine Corps? No.” I said, “I’ll tell you what, you can talk to your DI (Drill Instructor) about it.” Of course, that was that and there was never another time.

Recruiting Marines Years Immediately Following the Draft

Recruiting was different then. Recruiters got credit for everybody they sent to the yellow footprints. Nowadays I think they get credit for the ones they send who actually graduate. I don’t know in today’s volunteer world if they give credit to people who don’t finish boot camp. But again, this was a draft year and recruiters were scooping up everybody, literally. This is a true story. One day a DI brings this kid in, he says, “Doc, I’ve got this kid out there and there’s something wrong with him.”

“What’s wrong with him?”

“I don’t know. He’s a nice kid, doesn’t cause trouble, but he’s been here about three days and he just wanders off like he’s in another world. He’s not a trouble maker, he doesn’t talk back, it just seems like he’s not all there. I need you to look at him.”

I said, “Okay, bring him in.”

He brings him in, I take one look at the kid, “Jesus, gunny, he’s a god damned mongoloid!”

He said, “Whoa, whoa, we don’t discriminate, we take everybody, we take blacks, whites, mongoloids.”

"No, no, no gunny, not that kind of mongoloid. I'm talking about a guy with an IQ of about 60. That's why he's not following orders very well. How the hell did he get here?"

The answer was some recruiter. This guy got all the way through to the third day of training. I mean, back home, someplace some mother is wondering what happened to little Johnny is. Little Johnny wondered off one day and didn't come home one night. That's because little Johnny was put on an airplane and sent to the MCRD in San Diego.

It took me about 36 hours to get that guy back home.

That is unbelievable. In today's world that would certainly get a lot of press.

Sure it would. First, the recruiter nowadays doesn't get credit and the metrics aren't finalized based on how many guys they put on the footprints. They're looking at how many guys get through, particularly now in an all-volunteer force. Second, there's an attrition rate. Obviously, what the Marines want is every guy that was recruited to wind up to come in the Marines. The pool is too small and there's too many unqualified people out there. It's the recruiter, they need to be able to finish physically, emotionally, etc. There's no draft, but the Marines meet their quota the middle of every month. But they work very hard at it, they have very high quality because they want these people to finish. Back in the '70's the draft was on, the war is on. That's the Marine Corps, god only knows what the Army was doing. The Army had the lowest standards of any service. They might have had a whole company of guys like that.

The ‘70s was a different era. It’s hard to make people understand today the difference in the culture since the Draft ended. Remember once Vietnam ended we didn’t have any significant, large scale military contingency operations until Desert Storm. Prior to that there was Grenada, some stuff in Nicaragua, but little engagements. Also when the Draft ended, it took a generation to cleanse the services of all the draftees. Although we still had a lot of officers and senior enlisted who came through the draft, by Desert Storm the bulk of the fighting force was volunteer. By then the country was different. The country was over the anti-war, anti-military of the ‘70’s. Vietnam had been a very unpopular war and the military was unpopular. The military up to World War II was not unpopular. In World War II most of the male members in the United States had served. By the time we got into Vietnam, you had a lot of people in the service who were drafted who didn’t want to be in the service. We basically got in to Vietnam under false pretenses to begin with; there was the whole Gulf of Tonkin incident which turned out to be, probably, no more truthful than Bush saying there were Weapons of Mass Destruction in Iraq. Our incursion into Vietnam by Johnson was based on a shaky premise from the get-go. The country never bought into it. There was also a huge social-economic differential. In World War II, there may have been some deferments for those being in college, but nobody wanted them because you would be labeled a coward. By the time Vietnam came about there were two classes of people who were in the Draft. There were people going to college who got deferments, including me, and many of them never served. There were people going to Canada to escape the draft. There was this attitude, “Who’s stupid enough to be drafted?” The kind

of people, particularly with the Army that were on the front lines in Vietnam were often people of a poorer socio-economic status who didn't have the other alternatives that the more wealthy, more educated people could get out of if they chose to. In reality, I got out of having to enlist because I was in college. I knew at some point I was going to have to go in, but I wanted to go in after medical school, which is what ultimately happened. If I wasn't going to be a doctor and if I had went to grad school or something then I would have been eligible for the Draft. That's a big thing. I had a childhood friend named Sullivan who got drafted and stepped on a mine his first patrol in Vietnam and got blown to bits. His name's on the Wall. I've been to the Wall and traced his name. The difference between me and Sullivan is he didn't go to college, could have but didn't go to college. He got drafted and got blown up. It's a very different culture and climate in an all-volunteer force.

Back in the '70's traveling in uniform was a liability. People would spit on you, people would call you a "baby killer," stuff like that. Certainly nobody would give up their first class seat and giving it to somebody. The stuff that, the respect that is shown for the military now, didn't exist in the '70s. As a TMO at the end of the century there was a much higher quality Marine Corps, but it was a much higher quality everywhere.

SESSION 3: 20 November 2018

Surgical Residency at UCLA, Part 2

So, when we last spoke, you had just completed your tour at the Marine Corps Recruiting Depot in San Diego and getting ready to return to UCLA. You had mentioned in the two previous sessions that you had originally been interested in becoming a cardiologist. Why did you ultimately make that shift into surgery?

When I was in medical school I did my research in myocardial physiology and ended up graduating with an MD with distinction in research. My mentor was a cardiologist and it was his laboratory in which I did my research. And so I wanted to be a cardiologist because I was interested in heart physiology. The research I did involved doing open heart surgery on dogs and measuring oxygen flow in anesthetized and *in vivo* situations. For every experimental protocol that was set up there was probably an hour plus of surgery that went along exposing the dog's heart, putting in probes, things like that. Also, I worked as a diener and prepared the deceased for the pathologist to do their gross examination. I had these mechanical surgical skills that I was developing without realizing that I was developing them. And then as a student I became enamored and mentored by surgeons, so therefore, there was that switch. But, I still decided that, okay, if I'm not going to be a cardiologist, then obviously the natural segue is to be a cardiac surgeon.

While I was aboard the *New Orleans* I had the opportunity to interact with the three different surgical teams and each team had a general surgeon, an orthopedic

surgeon, and an anesthesiologist. I learned about the lifestyles of general surgeons and, also, I was facing the reality that while on active duty for two years, my residency was going to be interrupted for two years so everything was pushed back. Normally at that time you needed five years of general surgery residency prior to going into any kind of cardiac program; that's changed a little bit and now there are cardiac programs you can go into with only two years of general surgery. But basically a cardiac surgery training program was seven years; that and neurosurgery were the two longest residencies at the time. So when I was on deployment I started thinking about the lifestyle of a cardiac surgeon as opposed to a cardiologist and my desire to go back and work in a, maybe, less affluent population. To be a good cardiac surgeon—there's no point in trying not to be a good cardiac surgeon—you need a hospital that does cardiac surgery. There is a huge difference in the number of hospitals that do cardiac surgery as opposed to general surgery. Most of the cardiac surgery programs, or hospitals, are in major metropolitan areas; most of them are in the affluent parts of that metropolitan area. If you're a cardiac surgeon you've got to be surrounded by a very active group of cardiologists who are interested in taking care of patients with surgical type problems. You need a very dedicated pump team to run the bypass. So the supporting cast that you need to be a good cardiac surgeon, as opposed to a general surgeon, is very different. If you're a general surgeon you have the option of going into a rural area by yourself and having a solo practice. There's no way you can have a solo practice in cardiac surgery. You just can't. I never disliked general surgery and I had lots of mentors in general surgery, so as time went on while on active duty I decided that

general surgery was the best choice. When I came back to UCLA I said, “This is what I want to do.” It’s a long explanation, but it’s how it came about. It wasn’t a snap decision.

Was the intention to go through this residency and fellowship and then immediately return to the Navy?

No. When I left for active duty I became a free agent, so to speak. While in my second year I was at MCRD and I became more acutely aware of the Navy’s training programs. The Navy had good general surgery training programs. I went up to Balboa[46] and talked to the head of surgery and thought about the possibility of staying in the military and finishing my residency in the Navy program. They were very interested and wanted me to do that, but what they were offering were training programs in Philadelphia, St. Albans or Chelsea, Massachusetts. There’s a reason why I left Rochester for Los Angeles. It wasn’t because I wanted to continue a lifetime of shoveling snow at four in the morning, which is what I’d grown up with and it wasn’t very appealing to me. The war notwithstanding, I enjoyed the kind of professionals I encountered in the Navy and I was very attuned to the people that I was taking care of. From a cultural standpoint, I was okay with returning to the Navy, but not returning to the northeast United States.

So I went back up to UCLA and I talked to Dr. Longmire, who was the head of surgery and also a very famous pancreatic and biliary surgeon. He was one of the true giants and icons of general surgery, along with Halsted[47] and Sabiston[48] and others.

[46] Naval Hospital San Diego, CA

[47] Holsted, William Stewart (1852-1922). One of four founding fathers of Johns Hopkins University and early

When you look at the pantheon of general surgery history Longmire's there. Surgery programs are a little different now, but not that much different; surgery programs are absolutely not a democracy. The program director, the chairman of the department is omnipotent. When I started in 1970 there hadn't been any African-Americans before me; there hadn't been any women either. Surgery was very much a traditional male hierarchal organization.

Dr. Longmire had been an Air Force Reserve surgeon and was a colonel. And like most men of his era, he had a positive feeling about the military. It is hard to imagine, but back in 1970 you couldn't get elected to Congress if you weren't a veteran. So, he asked me what I'd been doing. I told him that I spent a year on a ship, went through what I had done and what I was doing at MCRD, which was taking care of recruits. And Dr. Longmire told me that his father had been a family practitioner in rural Oklahoma where he grew up. And apparently his dad got pretty sick at some point and after he finished his residency at Hopkins Longmire went back to Oklahoma and took over his dad's general practice for almost a year while his dad recovered from his illness. So Longmire said, "I feel like understanding a general practice is a good thing." He would always say, "I think the ideal surgeon is an internist who can cut." And so, the intellectual side of surgery, the diagnostic side of surgery was every bit as important to him as the technical side. He was a superb technician, but he was so much more than a pair of hands. And there are some surgeons who are mostly technicians. Somebody

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proponent of aseptic surgery among other surgical techniques.

[48] Sabiston, David (1924-2009). Legendary cardio-thoracic surgeon who developed seminal procedure that paved the way for the modern coronary-bypass surgery.

else takes care of the patients, they come in and they do the technical stuff and they're really not too much into the other stuff. But Longmire was a complete Renaissance surgeon.

So we had the discussion, I was sitting in his office and after about 30 minutes he looks up and he says, "Well, Jim, would you like to come back to the program next year?"

And I said, "Yes, sir, I would."

He then opens his center desk drawer and he pulls out a big, yellow legal pad that I can't see, all I can see is there's some writing on it. He pulls out a pencil and he erases one of the names on the pad and writes my name in. Surgery is not a democracy. To this day I have no idea who he turned to pencil dust, but that's the way it was. Somebody was eliminated and my name was written in. That's how I got back into my residency. This also gives you great clarity about performance, accountability, responsibility, etc.

Have you ever wondered about that other person's career path and where they ended up?

I have, but I have no idea who it was. He never said anything about it and I never asked him. Some things you don't talk about. You have to understand the drama of that moment of walking in not having applied for anything, not really appreciating that the 30-minute conversation was my interview. And I rotated out of the services in the first and second-year residents, so he needed me. And obviously he knew me because he accepted me into the program to begin with.

You're absolutely right. There's a lot of weight to that moment.

There is and that kind of drama doesn't need words. He was not a man of a lot of words. He had a very quiet voice, he never shouted or raised his voice. He never threw things in the operating room like some surgeons do. But he could change the inflection or the tone of his voice and literally turn you to stone.

Every Saturday morning we had grand rounds and the chief residents on each service would present the complications for the week and have to go into what went wrong, what was preventable, etc. etc.-not just for their cases, but if it was one of the attending's case on the service, the chief resident still had to present that complication as if it was his own as part of the training maturation of the surgeon. I can remember one Saturday, I forget what the complication was, but Longmire just looked up over his glasses and said, "Well, this wasn't one of your finest moments was it?" With an auditorium filled with all of your colleagues. The shame was just extraordinary. It was like you could cut the air with a knife.

But that shame and guilt is a crucial part of the teaching experience and maturation process.

Absolutely. At the end of the day, I remember students would say that surgeons weren't very nice. They were students that wanted to be psychiatrists, but they still had to rotate on surgery. And every now and then you'd get kind of a surfer dude who would come onto the service dressed rather casually. You have to understand, in general surgery you always had a coat and tie on, always. The only time you didn't, the only time you were seen on the ward in scrubs was if you were directly transferring a patient

from the OR, or had been summoned on an emergency like a cardiac arrest or something like that. Rounds were always done with coats and ties. The attendees had long coats and that was another, sort of, maturation. When you were a junior resident or student, you wore a short, white coat. That was sort of a white tie, and when you got to be chief resident, then you got the long, white coat. But, there was always a tie and always a collared shirt with a tie. This was the way things were at Hopkins; remember Longmire had trained at Hopkins and so it was very much of an eastern seaboard culture on the West Coast. Occasionally, we'd get a student that would show up wearing flip-flops and a Hawaiian shirt, and Longmire would say, "Tomorrow, you better look like the rest of us."

"I don't want to be a surgeon. Why should I do that?"

He'd say, "You want to pass this course? For the two months that you're on this course, this is what you have to do. When you're done, do whatever you want. But, while you're on this service, this is the dress code you'll go by and if you don't you flunk."

For some of these guys the idea of an autocratic situation was not something that they could understand or grasp. They were going into some specialty that wasn't going to be an issue for them, but the two months they were on surgery it was that way. I can remember one student saying, "The guy's a sadist. He really gets off on embarrassing us."

I said, "Whoa, whoa, whoa. Surgeons have to make life and death decisions, and if you made the wrong decision or the wrong judgement somebody dies or gets injured.

Bad things happen. And the environment in which we make those decisions is acute, stressful, and the body is being bombarded by catecholamines, and all kinds of fight or flight hormones. So, when we're on rounds and we're challenging, we're picking on you, I always like to say, it's akin to getting your catecholamine level up. Embarrassment gets your catecholamine level up to show the ability to make the right decisions under those stressful circumstances." I said, "Also, it's a lot of fun." We really are the sadists.

Was there a notion that surgeons are atop of this medical hierarchy?

Absolutely. Within the surgical community neurosurgeons and cardiac surgeons are sort of at the top. In the 70s, the degree of some specialization that we have now didn't exist. General surgeons did everything. Only in the last twenty-five years or so have we seen the greater specialization among orthopedic surgeons, by urologists, head and neck surgeons. Originally, everything that is a province of the specialist originated in general surgery. General surgery is the origin for all surgery. When Dr. Longmire was trained pre-World War II, a surgeon did everything other than orthopedics. Head and neck surgery, otolaryngology was primarily working on science- they didn't do any of the kinds of stuff they do nowadays. Major reconstruction for plastic reconstructive surgeons was all part of general surgery.

In addition to general surgery, Longmire was the architect in developing top flight subspecialties at UCLA, each one of which became the pick of the litter within its field. He allowed that development of sub-specialization even though it was in competition with some of the things that were in the purview of general surgery.

Back in the day, the *Maddox Textbook of Surgical Techniques*, two big volumes that had a lot of illustrations, and it's kind of a how do you do it for various operations. In 1970, when I started my residency, cardiac vein bypass surgery didn't exist, it was experimental. In fact, I scrubbed on the first coronary bypass surgery at UCLA. Prior to that, they had developed a technique called endarterectomy, which sort of rotor-routed the inside of vessels, the heart, legs, etc. Back in 1970, if you looked at the chapter in coronary artery, endarterectomy, which is an open-heart cardiac procedure, that chapter was written by Dr. Longmire, a general surgeon. So, that tells you something about the scope and the breadth of surgery back then. Nowadays, there are all kinds of subdivisions within general surgery- colon/rectal, trauma, and vascular surgery are their own certifiable subspecialties of general surgery. So, there are a number of subspecialties and surgery apart from specialties that stand, sort of, equally. So, in most places peripheral vascular surgery is a division within general surgery as opposed to orthopedics, neurosurgery, which are independent departments within the hierarchy on par with organizations on par with the general surgery department.

Longmire was one of the giants that developed a lot of different surgical techniques and developed ways of training. He was known throughout the world and always had people who were what I call high-class VIPs from some foreign country who were at UCLA because Longmire was going to operate on their pancreas or whatever.

Are you a member of the Longmire Surgical Society?

I'm not only a member, but I was the last group of residents that he personally trained before he retired. So, while the Longmire Society is something that all resident

become members of when they finish the program, my unit was the last unit Longmire personally trained.

Returning to the Navy

You went into private practice following your residency before ultimately deciding to return to service. Why did you decide to return the Navy?

When I finished my residency in 1977 I stayed on as a junior attendee, sometimes called the “super chief” year. That year you are no longer a resident and it was the first year of being an attending physician and a member of the faculty. You oversaw one of the services who were the non-private patients and he was sort of the attendee that oversaw the non-private side of any given service. And then the way reimbursement went, you would make rounds with the residents, including chief residents who dictated little notes on each patient, which was transcribed and put in the chart. That note is what got extra payment under the current reimbursement system. So, the role you play is an important money maker for reimbursement. They were getting more money for the non-private patients that they would have otherwise. The non-private patients from a reimbursement standpoint to a level reimbursement that is more equal to the private side. It also gave you a year to decide where your niche was going to be and it allows you to put together what you want to do in the longer term. Do you want to go into more research? And obviously you got paid more than you did when you were a resident too.

During that time I looked at my options and the time I spent in the Navy. I liked the Navy as a community. My brother had graduated from Drake Pharmacy School and was set up in a pharmacy practice in San Diego so I had ties to San Diego outside of the Navy. And looking at the private practice situation, I knew physicians in San Diego because while I was at MCRD I had also been invited to some of the emergency rooms and gotten to know a lot of the physicians and some of the surgeons. An opportunity came about with one of the surgeons that had been in solo practice for about ten years and was looking for an associate, and so that opportunity came about and I decided I would go to San Diego and go into an independent practice as opposed to spend it in an academic environment.

When I was in the Navy I thought about a solo practice as opposed to the academic environment. Again, one of the things that made general surgery much more compatible with me was it was the option I could afford. I could have stayed in academics at UCLA, but I ultimately decided to go into private practice. My office was in an area that made it very accessible to the lower socio-economic population. I also attended emergency rooms in the affluent areas, so it gave me a diversity of practice that I enjoyed, and I was there for five years. Then around 1980, a couple of important things happened. First, I got divorced and second, the practice of medicine began to change after Ronald Reagan was elected president. It's an interesting phenomenon- doctors are a fairly conservative as a group with most supporting Republicans over Democrats. A typical doctor back then would have been supportive of Reagan. What's not as well appreciated was that Reagan's policies were an anathema to independent

private practice, and were more beneficial to group practice. These were policies that favored physicians working directly for hospitals and corporations, which in the 50s, 60s, and 70s never happened. Kaiser Permanente was an anomaly compared to the norm for physicians at the time. But it always amazed me how much the medical establishment supported Ronald Reagan when at the time the majority of physicians were still in an independent practice as opposed to working for a hospital. The policies of the Reagan administration were a direct assault on the kind of practice that most physicians at the time enjoyed, and that had to let up. Solo independent practice today is virtually unheard of. When someone finishes their residency now, irrespective of specialty, they're looking for what kind of group practice they are going to go into.

At the time I had a very lucrative practice. I was billing probably a quarter million dollars a year, doing very well, serving the community that I wanted to serve. But when you're in independent practice, there's also a business side to it and one of the biggest problems of business side is your cash flow. So, you perform a service, an operation, and you have to wait to get paid. Rarely do you get any money up front for what you do. Starting in 1980, lots of things became to change. More and more populations were being divided up into target populations. For example, nowadays you have Medicare Advantage when Medicare pays a physician group/hospital group to take care of a defined population of patients that they're responsible for. And they tell you what your reimbursement is, etc., etc. Prior to 1980 that sort of thing didn't exist very much. Once Reagan came into office, there was a great move toward that style of practice where populations of patients belonged to an insurance company, belonged to Medicare,

belonged to some third party element. And that third party element would develop networks and get into contractual relationships with providers. This is SOP now, but in the early 80s, this is when that sort of thing was beginning to develop. So, my referral base, generally speaking, emergency rooms I covered or the primary care doctors who were in the building where I had my office, or in the general area. And you would get your referrals through the relationships you built with your referring doctors. As the third party payers began to take up populations there were restrictions, so if you weren't in a network you couldn't get access to those patients that that network covered. So suddenly, in the matter of sometimes weeks or days, I would be cut off from people I'd been doing business with throughout my practice because they were in a different network than the one I was in.

The trauma system and the indigent population were put into a selective system—somebody now owned them, so to speak. All of a sudden, in the midst of a complicated divorce and whatnot, my practice was threatened because suddenly I no longer had access to some patients, because I wasn't in their network, therefore, I couldn't get paid for taking care of them. There was a lot of turmoil. There were people who would come into cities all over America with these new programs of plans that you could join, some of which turned out to be, upon further review, Bernie Madoff[49] kind of stuff. I can remember one of my colleagues who was operating on a patient doing a Whipple procedure[50]-it's as complicated an abdominal procedure as you could get.

[49] Madoff, Bernie. An investment advisor and swindler behind the largest Ponzi scheme in American history. It is estimated that he cheated his clients out of $64.8 billion dollars.

[50] Whipple procedure (AKA, pancreaticoduodenectomy) is a complex operation to remove the head of the

When the patient woke up from the procedure that insurance company and that preferred priority plan that she was a member of had gone bankrupt. Literally during the eight-hour procedure she'd gone from being well-insured to not insured, and that was happening all over the country.

One thing Reagan was doing, and while he was assaulting independent private practice, he was also building a 600-ship Navy. I started thinking about returning to the Navy. The military offered me a steady cash flow and I no longer had to worry about collections or malpractice insurance. One day I went down to the recruiter in San Diego and he looked me up and he said, "Oh, you still have a Reserve commission."

I said, "I haven't been drilling in years."

He said, "It doesn't matter. You're still on the rolls. Actually, bringing you in is quite simple. I can bring you in as a recall to active duty. It would take about two weeks."

I looked at the situation and at the time I'd remarried, I had a child on the way, I had adopted my second wife's son, so I was looking at four kids. I had, at that point now, four kids, a relatively new bride, and my mother and her mother, both of whom had health challenges and both were widows, and coming back into the Navy eliminated a lot of problems. I eliminated all kinds of insurance-health insurance, disability insurance malpractice insurance, and liability insurance on my office. The day I came back in I eliminated two to three thousand dollars a month in insurance. When I ran the numbers the amount of money that I could take home to my family was about 15 to 20 percent

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pancreas usually as a means of removing cancer. It is named after Dr. Alan O. Whipple (1881-1963), the American surgeon who pioneered the procedure.

less than what I was making in private practice, but it would come instantly on the 15th and the 30th-there was no cash flow. It didn't matter where I was, it didn't matter what I was doing on the 15th and the 30th-X amount of money was going to come into my account without fail.

I was coming back in as a lieutenant commander, which for a general surgeon was, was, like $25,000 or $30,000 in a lump sum. When I came back on active duty, not only did all of this overhead expense go away, not only did my cash flow problems go away, but I got this huge bonus, almost like a signing bonus that appeared within a week or two after I came on active duty. And when my child was born at Sharp Grossmont Hospital the Navy paid 100 percent of it. They promised me that I would be stationed at either Camp Pendleton or San Diego and they guaranteed that for three years. So, I found myself at the surgical department at Naval Hospital Camp Pendleton. With seven other surgeons. I was now part of this practice of excellent board-certified surgeons; not only did the economics of my life change, it was a culture that I liked.

Navy Medicine in the 1980s

You're returning back to the fold at a very difficult time in Navy Medicine's history. We have the Billig Scandal, the massive reorganization, and problems with recruiting. What stands out in your mind about that period?

The 80s was a very troubling time for both military medicine and civilian medicine. There were a lot of things going on. Reagan's policies undermined a lot of the line; Reagan's policies were bad for what I call solo practice, or independent practices. But in the 80s there was a lot of evolution and changes taking place. Remember, the

country had practiced a style of medicine that was pretty much the same, more or less, as in the nineteenth century. The military was pretty much the same way in terms of the draft. The draft came just before World War II and remained through the Vietnam War. By the 80s, the draft was gone. It hadn't been gone a decade yet, so the question remained how do you maintain a military when there's no draft? How do you access people who don't have the draft hanging over their heads? How do you recruit physicians who are no longer subject to the draft? Why would anyone come into the military? I had good reasons for it. Civilian practice compared to military practice wasn't attractive. The economy was moving along well and the military itself was dealing with people exiting as soon as they could; that was one of the reasons why the bonuses came into play. Congress passed the bonuses to try to stem the vast tsunami of doctors leaving as soon as their obligated time was up. Prior to the early 80s, there was no big bonus because you used draft doctors like anybody else. Most of the bonuses that we take into account we assume in a volunteer force; that stuff didn't exist in the draft era. There was a little extra compensation for pilots, but we didn't have things like reenlistment bonuses. We didn't need to; you could draft people. So, that was huge.

The other thing that was huge was: as third-party payers-the insurance companies, the government, became more and more involved in the reimbursement flow. And the number one determiner of the process, the system that drives reimbursement, the standards that drive reimbursement, who do you think the number one standard bearer is for that? Who develops the standards? It's Medicare. Remember, healthcare in America is fundamentally a state's rights issue. All 50 states

license their physicians; they all determine some kind of standards. There is no national licensing for physicians and medical providers. There are no national standards. If you violate the standard of care it's based on the standard of care that existed in the region that you are practicing. So, if you screw up in California, the standard by which you are judged is how that particular specialty is practiced in California-not New York, not Mississippi-but California. So, the entire system was governed by 50 states loosely held together.

What Medicare had at the time as things were developing was something nobody else had including insurance companies—Medicare had a national database. The Medicare insured population is in all 50 states. So, irrespective of whatever local or state standards there were, Medicare developed standards that drove reimbursement. When they were challenged on it by the insurance companies, nobody had matching data because nobody had a database that involved all 50 states and territories. Only Medicare had that. And they developed some things that were based on aggregate population group studies that nobody else could match. In fact, nobody can still match. So, when you look at how we reimburse, whether it's fee for service, whether it's group contracts or whatnot, it's not that Medicare is the best payer—they're not—but if you look at the methodology for how you set up standards and you connect them to something that's going to drive reimbursement, Medicare is the standard created for everything. Most people don't understand that. Most people who make the argument against socialized medicine don't understand that we're already in socialized medicine. We have been for decades because the standards by which reimbursement is driven is

run by CMS,[51] which is a government organization. The entire military reimbursement—as well as the VA's—is based on CMS rates. So, when you look at the Medicaid population, the military and the VA, all those federal agencies, their reimbursement and quality control is all based on what Medicare has devised. And when you look at Blue Cross, they may pay more money and may add some more wrinkles to it, but the fundamental skeleton by which they're reimbursed is basically based on CMS. Like the Federal Reserve, we can do whatever, but when the Federal Reserve sets the benchmark interest rate, all the other interest rates are related to that. And in healthcare, it's the same basic model. Everything's related to what CMS is doing when it comes to reimbursement, and this is America-if you always want to know what's going on in America, follow the money.

So, this whole issue of how standards were being done, the methodology-the teeth of that was all developed during the 80s.

Quality control was also being developed then. The 80s was when Deming[52] rose to prominence. Deming was a guy who actually put forth his philosophy in the 40s and 50s. After the war, he went to Detroit and talked to the big automakers about instituting his studies and they said, "Get out of here. You're an idiot." You know, "America's going to be on top for the next 200 years because nobody can match us and why would we

[51] CMS (Centers for Medicare & Medicaid Services) is a federal agency that administers Medicare.

[52] Deming, W. Edwards (1900-1993) was an American engineer, statistician and management consultant. Famous for his *Fourteen Points of Effective Management*. The Deming Prize has been sponsored since 1951 by the Japanese Union of Scientists and Engineers to recognize individuals for their contributions to Total Quality Management (TQM), in honor of Deming's contribution of statistical quality control that greatly contributed to Japan's manufacturing success after World War II.

change what we're doing." They threw him out, basically. So, he wandered around in the wilderness for a while and he wound up going to Japan. The Japanese had a different attitude. They had two major cities that had just been turned into glass; they were on the bottom and they were very willing to listen to different ideas, because their ideas had clearly not worked. And so, Deming's whole philosophy of continuous process improvement got its start in Japan because the Japanese were receptive and the Americans weren't. And that was the basis for the change in automobile manufacturing and within 10 or 15 years, the Japanese were on top making cars.

In the 80s that same sort of continuous process improvement, or continuous quality improvement, took hold in the United States and you began to see it all over the place, even in the medical community. Not only how to evolve reimbursement, but how do we evolve quality. And the Navy had its own particular problems with Billig.[53] The Billig affair was a scandal at least equivalent to Tailhook and Fat Leonard where you had complete failure and breakdown of leadership. The Navy, because of the exodus of physicians-particularly high-end specialists—went in the crapper and all the doctors left. So the Navy was in a position where they really didn't have cardiac surgeons in

[53] Billig Scandal. CDR Donal M. Billig, M.D., MC, USNR, a cardiac surgeon assigned to NNMC, Bethesda, on 26 February 1988 was convicted by general court martial of two counts of involuntary manslaughter, one count of negligent homicide, and 18 counts of dereliction of duty; and sentenced to four years confinement at Fort Leavenworth, KS. He was released after serving two years of his sentence when his conviction was overturned on 14 April 1988 due to insufficient evidence. Billig had joined the Navy in 1982 after being dismissed from a private medical group in Pittsburgh, PA, and before that had been forced to leave Monmouth Medical Center, Long Beach, NJ, after losing his surgical privileges. He returned to private practice in Maryland after his release and died on 9 December 2009. See "Navy Surgeon is Convicted of 3 Patient Deaths", *NY Times*, 26 February 1988; and "Military Court Frees Jailed Doctor", *LA Times*, 15 April, 1988.

Bethesda, Portsmouth, and San Diego. They were getting into all kinds of workarounds with the civilian sector, because if you don't have these programs, then all of your training programs are in jeopardy, no matter what the specialty is. The fundamental training programs are tied together and if you lose one you're in trouble. A general surgery program in an institution that has no internal medicine training program is always in a marginal accreditation status. So, cardiac surgery is what I call a loss leader. If you don't have it lots of other things happen, so the Navy was looking at that fact.

Billig was a cardiac surgeon from New Jersey, as I recall, who had had some bad outcomes, in part related to the fact that he had a visual problem, which came out later. And he was actually on probation from his hospital in New Jersey. It was well-documented; it was not a secret. His limitations had been outlined by the private sector. But the Navy hierarchy at the time brought him in to beef up the program at Bethesda, and they essentially ignored all the things that were going on in the civilian sector. He should never have been accessed, that's the bottom line just based on professional considerations. So, he came into Bethesda and killed a couple of people, ultimately because of his physical and professional limitations. This had been well documented in the civilian sector but the Navy leadership covered it up. And then the Navy tried to court-martial him by criminal negligence. He was convicted, but ultimately that was thrown out because it was clear that while he had limitations it was not criminal. He was a bad surgeon and his limitations were well known. Billig himself didn't hide anything. It wasn't that Billig defrauded the government-snuck in and hid stuff-the information was

there and the Navy just ignored it. So, my point to all that was once that was done, Navy Medicine and the Navy line had reason to pay attention to the things that were going on in quality improvement and Navy Medicine moved to the forefront of quality improvement and was way ahead of the other services. And that was something that came directly out of the Billig scandal.

The other thing that was going on was that the Navy had lost its way with CPHP (Clinical Pathway-Health Professional) program.[54] It was just awful.

Who was pushing this program?

Mostly people who, thankfully, their names have been lost. I'm sorry, but I have to be very frank and I may ultimately step on some people's toes but what can I say?

Back in the 80s, the hierarchy was physician- dominated. Nurses were not where they are today. Neither were the MSCs. Dentists didn't get much beyond the 32 teeth. I'm serious. I know it sounds a little cavalier, but it's true. There were elements, particularly within the MSC community, who always felt that running hospitals was an administrative duty. And again, the model that evolved in the civilian side, remember, was different. If you looked at a typical civilian hospital, the civilian hospital was run by a hospital administrator whose background in training was healthcare administration, basically an administrative MSC. It's not doctors for the most part. So, you have all

[54] In 1986 (ALNAV 086/86), the Chief of Naval Operations and the Surgeon General established a two-track professional—Clinical Pathway-Health Professional (CPHP) career program for senior Navy Medical Department officers. The CPHP program was conceived to enhance Navy Medicine by significantly improving personnel management and by ensuring talented and experienced people are assigned to the right jobs.

these guys in the MSC hospital administration community who felt like doctors shouldn't be running hospitals. This was a power grab.

The Secretary of the Navy at the time was John Lehman[55]-one of the low points of the Department of the Navy. Lehman was a guy who couldn't teach anything. He knew everything because he was a Reservist and he was a flyer, so of course he knew everything. He had a very low regard for people in uniform. He was like (Robert) McNamara in that regard, or (Donald) Rumsfeld. All three of them "knew everything," and were "smarter than anybody else." Lehman didn't know anything about medicine. Lehman's brother-in-law, however, was a physician at Washington Medical Center, in one of the D.C. area hospitals. I don't know what his specialty was whether he was a surgeon or whatever, but, his brother-in-law was an active physician in the D.C. area and Lehman went to him and asked, "How are things going in the civilian sector?"

And the brother-in-law said, "Well, doctors don't run hospitals. Doctors run the staff. They have staff troubles and all that and then an administrator acts and runs the hospital. And that's how it started. And then he found a receptive ear, particularly among some of the MSC leadership at the time and they said, "That's the way it should be." And the next thing you know, we had this CPHP system where the clinical providers were going to have their own thing like the civilian staff, flag officers, etc., etc., and they would be in charge of all the doctors. Everybody else, including all the nurses-anybody who wasn't a doctor or a dentist-was moving to the HP side, including all the support personnel. So, if you were a corpsman or a technician, a nurse, it didn't matter.

[55] Lehman, John F., Jr., Ph.D., Secretary of the Navy, 1981-7, (appointed at age 38); later retired as CAPT, USNR; currently Chairman, J.F. Lehman and Company, a private equity investment firm.

The only people who were going to remain on the CP side were MDs and DDSs, and they were going to have their own hierarchy of flag officers. If an MD or a DDS was going to be on the HP side they had to have an HP kind of degree, like a master's of business administration, etc., etc. So, this got passed and there was an anesthesiologist named [redacted][56]—total idiot—he was one of these guys who went into a residency and never practiced. He went to a residency to "give himself a legitimate clinical portfolio," and then as soon as he was done he immediately went back in administration and never practiced medicine. At any rate, he was in charge of going around and explaining, particularly to the doctors, what this new change would be. I remember being in the auditorium at Naval Hospital Camp Pendleton and listening to this long spiel and I asked him, "Well, the way this is set up it looks like the clinical side will be doctors and dentists and there will be this hierarchy. It looks like everything else will be on the HP side. So aside from worrying about some of the professional oversight of doctors and dentists, where are the responsibilities on the clinical side going to be? Looks like nothing else."

And he looked at me and he said, "Listen, you just need to get onboard with this. Get your head in the right place." And he went on to another question.

So, it was guys like him who were going to be running the CP side. [redacted] was a guy who couldn't make it, so guys like him liked this because it gave him a pathway to being a flag that under the old system he would never have gotten. He was never going

[56] [redacted]

to be good for the responsibilities of leadership, including running a hospital or anything else. I mean, you could see where this was going. The doctors didn't like something the nurses were doing and it required cooperation. In essence, everybody else was going to be like in a union and they could tell the doctors to go screw themselves. And it was just madness.

But thank God Zimble[57] came along and put a stop to it. Admiral Zimble had spent the last several years of his career in the 80s with the line, and so, he had an operational mindset as to how things should be done. In 1987, he got the nod for SG and the first thing he did when he came into power was he literally shit-canned-pardon my French-this process. Unfortunately, the MSCs, prior to his coming in had already made changes and had cut orders, so when Zimble took over, the MSCs had all the hospitals and the doctors had their CP.

At the time Admiral Higgins[58] was my CO at Camp Pendleton back in '87. He was one of the folks who was tapped to be an admiral on the CP side and he was replaced by an O-6 MSC officer,[59] and basically, virtually every hospital in the system had an MSC, because the nurses had not yet evolved to the point where they had that kind of hospital business administrative education and training. So, virtually every hospital and clinic, including Bethesda, including Balboa, now had an O-6 MSC running it, which was the other thing. All of a sudden the flag officers that had been running the

[57] Zimble, James, VADM, MC, USN. Surgeon General of the Navy, 1987-1991.
[58] Higgins, Robert, RADM, MC, USN. CO, Naval Hospital Camp Pendleton, 1986-1987; Deputy Surgeon General, 1987-1991.
[59] Lashley, K.L., CAPT, MSC, USN, CO, Naval Hospital Camp Pendleton, 1987-1989

major medical centers were all now being run by O-6 MSC guys with some sort of regional admiral in charge of the whole thing. So, it was a power grab by the MSCs. Zimble saw through that and immediately got rid of it and within a couple years all of the hospitals had flipped. But before this. The MSCs, of course, were in charge of the ordering process, and the minute that Zimble looked like he was coming in, they short-toured everybody. I mean, Higgins did not serve a full tour at Camp Pendleton. All of a sudden he was gone, and there was a period where the MSCs had all the hospitals and there were all these CT admirals sitting around the four-star towers at Bethesda-Higgins-six of them. They were all sitting around there just waiting around. It was a bad time. But, like I said, that all happened because the MSC hierarchy was very influential and powerful, and Lehman, the Secretary of the Navy, talked to his brother-in-law.

The Differences between the Services and the DHA

The Army and the Air Force are garrison services. The Navy has always been an expeditionary service. That culture leads to different ways of looking at organization, mission, etc., etc. We see what is going on today with the DHA. It's perfectly obvious that Military Medicine is going to be hollowed out. There's no getting around that. People have been wanting to do that since the 80s. Ever since the draft ended people have been looking for a way to say that Military Medicine is no different than civilian medicine. Why are we spending all this money?

The simple lesson is when you make decisions that are focused primarily or exclusively on the bottom line then you will get to a decision, whatever it is, that doesn't

address the fundamental mission of whatever you're talking about. In spite of all the advances in technology and all the stuff we have in the 21st Century, the most important piece of the puzzle are still people. They are the most expensive part of the puzzle, and particularly if you don't do it right. Bad medicine has always cost more than good medicine and in order to practice good medicine you have to understand what the fundamental product of medicine is—it's people. It's not machines, it's not standards or any of that stuff. It's fundamentally the practice of medicine-the science, the art, whatever you want to call it-it's in your people. And when you lose sight of that or when you develop programs that address the bottom line and forget about the people part, it's always going to be a poor system. It's not going to get the desired outcomes. And over and over again we keep making that mistake to some extent because of people who don't understand the basic mission-never experienced it. They're not the people making the decisions. They're not the policy influences.

It doesn't matter what profession there is always a legal aspect to it. I don't care if it's medical, dental, automobiles, it doesn't matter. The oversight process for any profession, for any entity, involves the legal profession, correct?

Yes.

Okay, the legal profession is the only profession that, generally speaking, the oversight doesn't involve somebody from outside that profession. Only lawyers can oversee lawyers. Only lawyers can determine what the standards lawyers should go by. Only lawyers can be on the Supreme Court. Everybody else, no matter what you are, lawyers can be involved in everybody else's business, and are, but nobody else gets to

be involved in theirs. So, when you develop a system that is legally focused, or economically focused, and not people focused you are developing something that doesn't work. It's like developing computer programs, you never talk to anybody other than a coder who puts together something that makes absolute sense of the prospective coder that makes no sense to the end-user. How many times have you written computer programs and devices that are completely user-unfriendly?

Now, there's less of that today because of millennials, and they have grown up with devices and are plugged into them from the time they take their first breath. So, you get by with some of it. Whatever we do, we'll probably get by with it, not because it was well-designed, but because there are some things that have changed in the practice of war. Wherever we have a conflict, whatever part of the world it is, we will stabilize our casualty. Once that casualty's stable for transport and they can no longer be part of the basic mission, whatever that is, they will be sent to a regional location, where they'll be further stabilized so they can be flown to the United States. So, that means even the severest casualties within three to seven days, no matter where it happens, will be back in the continental United States mostly-Alaska and Hawaii being regional transfer points for Asia, like Landstuhl-for Europe and the Mid-east the purposes of casualty care. That means definitive treatment will be down in the continental United States no matter where you got your injury. That means that whatever definitive capability that you need to take care of can happen anywhere. There's no longer an absolute need for a VA, for military, for anything. If the capability for what you need is at the Mayo Clinic, as opposed to Balboa or any other place, then what's to keep you from going to the Mayo

Clinic? Two things: policy and funding. Is there a policy that allows you to go there? And is there money to pay for it? If the answer to both of those things is "yes," punch the ticket.

And that's fundamentally changed-that fundamental change as to how we care for our casualties really hit its major stride in 2003 when we stabilized casualties to FRSS's[60] and whatnot. We sent them to Landstuhl, and now our KIA rate is single digits. Last time I checked it was seven or eight percent as opposed to 25 or 30 percent in previous wars. And people are back here in the United States. If you need to be in a major burn facility and you're in Texas, go to Brooke[61] because Brooke not only has the capability, Brooke is the burn center for that whole region of south Texas, civilian and military. And it's been that way for a long time. So, how does that work? Well, it works because there's funding and an agreement to allow it to work.

So under DHA, I believe that Military Medicine will be hollowed out and we'll wind up with something that looks like Canada where if you need something definitive done, you go into the socialized healthcare system, and when you've recovered from that, a military doctor, or someone who understands military standards, checks you out and gives you an up check or a down check for returning to active duty.

But the person that is actually taking out your gall bladder does not have to be someone in uniform. So, you'll hollow out the force-and this is particularly important to the Navy because the Navy's expeditionary, much more so than the Army and the Air

[60] FRSS (Forward Resuscitative Surgical System)

[61] Brooke Army Medical Center (BAMC) is the United States Army's premier medical institution. Located on Fort Sam Houston, Brooke is a 425-bed Academic Medical Center and is the Department of Defense's largest facility and only Level 1 Trauma Center.

Force. We have these specialties that don't even exit. There's no submarine service in the other services. The whole nuclear propulsion doesn't exist in the other services. I mean, the other services have nuclear weapons and there's a whole thing about dealing with weapons and all that sort of stuff, but we're the only service that propels our craft with nuclear energy. We're the only service that operates above the planet's surface, on the planet's surface, and below the planet's surface. Our specialty is operating in the environment that covers 60 percent of the Earth's surface. So, there are things that are unique to the expeditionary mission of the Navy that don't even exist for the Army and the Air Force. And so the hollowing out from an expeditionary standpoint threatens the Navy more than anybody else.

Concept of Readiness

What is your take on this concept of readiness?

It's really simple-at least for me it's simple. Readiness is the point of the spear. It's the forward aspects of what our mission is. The basic mission of the Medical Department, of medical personnel, is to support and defend the Constitution of the United States against all enemies foreign and domestic. We hold up our hand and we don't pick a different oath than our line counterparts. We take the same oath; it's the same mission. The difference is what is your specialty? What is your area of expertise for carrying out that mission? Are you a sonar tech? Are you a corpsman? Are you a gunner? We all have specific missions within that, but the fundamental mission is the same. So, that's point number one; if people don't understand that, as far as I'm

concerned, we're never going to get to you from there. And I submit that, unfortunately, the majority of people—even in uniform—don't understand that.

Differences between Navy Medicine and Civilian Hospitals

The mission of an MTF is to do all the things that happen in a civilian hospital, and it's also to hold and train the cadre of people and experts that are necessary to go forward in contingency environments on a moment's notice. Now, maybe if you had everybody in the Reserves and you transferred that mission to the civilian sector, it would still work, but I don't think so, that's not a mission of a civilian hospital. The Reservists who are in civilian hospitals require laws so that they can go forward and their job isn't taken away from them while they're gone and all that kind of stuff. Transferring the mission to the civilian side doesn't seem to work all that well. It didn't work all that well in the Draft-era, and how the hell is it going to work in the volunteer era?

So, at any given time, the model that works best for how to organize medicine has already been there. We already do it. It's called the Special OPS command. Special OPS is a combatant sync. They have people forward all the time doing missions in all the services. At the same time, they have a functional mission like TRANSCOM[62] and other functional combatants, which is to train and equip, etc., etc. What's unique about Special OPS command compared to other military commands is the military commands are either supported CINCs or supporting CINCS. CENTCOM, Seventh Fleet are

[62] United States Transportation Command (USTRANSCOM) is one of ten unified commands in the Department of Defense.

supported CINCS as opposed to supporting syncs, like Third Fleet, NORCOM, etc. For the line side of the house, it's either or, except for Special OPs, which is both. Medicine is just like Special OPs, it's both at the same time. At the same time, you're fulfilling the "train and equip" mission; on a moment's notice, those same people go forward to carry out the contingency operation whether it's on the *Mercy* or the *Comfort* or with the Marines or wherever. That's the fundamental model. I've never understood why there's all this head-scratching about how to organize when how to do this is like Special OPs. The way they're organized works very well. It's not a mystery to the line. Every service understands because every service has skin in the game for Special OPs. It's always been there, but we don't pay attention. We don't pay attention to our own wisdom. Never have. I mean, that's been apparent to me. And again, part of it, perhaps-I personally don't think I have blinders on my eyes-goes back to how I was introduced to the Navy to begin with. Remember, I came into the Navy on two weeks of orientation and I went away for almost a year through every kind of operational challenge you can think of. That was my introduction to the Navy, and my first shore career was at MCRD, which was about the business of how you take a civilian who knows nothing and turn them into a warfighter over the course of twelve or thirteen weeks. That's how I was introduced to the Navy, to the military and then I went back and finished my residency and when I came back I went to Camp Pendleton, which is full of operators. I mean, my whole orientation in the military has been fundamentally based around the operational issues; those were my first three tours. So it's always been apparent to me how we should be doing things. But, there are too many people who don't have that perspective.

And of course, now, it's all about the money. You've got a Congress who doesn't have a clue that most of the country doesn't have a clue. Like I said, we may stumble into this getting this working just because we have changed how we manage the casualties. The Canadian system-if you have the right incentives and everybody's lined up-could work for us. I think it's culturally a big gamble. The Canadians, culturally, act quite different from us. Canadian's military is pretty much dedicated to a mission of peace keeping. If you look at any peace keeping organization run by the UN, there's almost always a Canadian contingent, same with Scandinavia. These are countries that have the lowest rate of focus, but it's oriented on peace keeping. They're very good at it, but their military isn't oriented to the kinds of missions that the United States has always had.

And the civilian system which you go back to is a socialized system. It's that way for Canada; it's that way for all the Scandinavian countries. It's that way for the UK. So, when you take that military guy and do the incentive work and send him to the "civilian side" you're sending him to an over-socialized government backed system that people are arguing about whether or not that's the right thing to do. You don't have anybody arguing in Canada, or those places, about socialized medicine. What are you talking about? We're having this fight in this country when the country doesn't even realize that more than half the country is already in a socialized system in terms of whose providing their care. And a hundred percent of the country is in a socialized system when you look at the system of reimbursement in terms of standards.

Naval Hospital Camp Pendleton

I had spent almost five years in private practice in San Diego, and then almost five years at Camp Pendleton. So, I had been out of the academic mainstream for about ten years and intellectually I was ready to move back into that academic situation. I had ten years of doing all the surgery that I wanted to do, needed to do on my own or with a group of other practicing surgeons, and I was mature enough and intellectually prepared enough to be comfortable teaching residents again and letting them do stuff, so it was the right time in my life to commit to that. But that all changed in the fall of 1989. When Zimble took over Navy Medicine he selected Admiral Higgins to be his Deputy Surgeon General and also the Chief of the Medical Corps. So, Higgins called me up, and I'd had a very positive relationship with Higgins when he was CO of the hospital. Whenever the executive officer was away Higgins liked to rotate the acting executive officer position amongst his senior people. So, I forget the executive officer's name, but he was going away for a week or something like that, and Higgins made me the acting executive officer because I was the director of surgical services at the time, a position that (Donald) Hagen[63] had put me in when he was the CO there, even though there were three O-6s ahead of me. I was the DSS when Higgins took over from Hagen, so I was one of the people that would be an acting XO, so long story short, the XO was going somewhere fun. I forgot the XOs name-he was kind of a putz. And I went into his officer on like a Friday afternoon-he was leaving and would be gone all the following week, so he was showing me around the office and telling me what I had to pay attention to while

[63] Hagen, Donald, VADM, MC, USN. CO of Naval Hospital Camp Pendleton, 1984-1986; Surgeon General of the Navy, 1991-1994.

he was gone, and there was all this paper stacked everywhere, which were the things it turned out needed to be done, and he opened a couple of drawers and he said, “If something comes in and you can’t find it amongst the stacks of things on the back of the credenza here, look in one of these two drawers, it may be buried in there.” Literally. And then he left. So, it’s like mid-afternoon on a Friday, I start looking through this stuff and thought, “This looks like paperwork that should have been taken care of.” So, I called my wife up and said, “I won’t be home this weekend.” I literally stayed there the entire weekend, quite literally stayed there from Friday to Monday, and did not go home. And I went through all this stuff and moved it into the COs office and he signed off on all of it that was supposed to be done, researched it and what not. Higgins came in on Monday and wanted to know what the hell all of this stuff was. And I told him there were a few things that I knew needed to be moved so I moved them. So, I basically spent the weekend and did what turned out to be about three months’ worth of work that I did in three days and put it all on Higgins desk, and he was flabbergasted. That XO, when he came back, wasn’t the XO very much longer.

One day I get this phone call from Higgins when he his at BUMED, and I’m actually at some leadership conference up in Orange County. He calls me up and says, “I’ve been recently made the Deputy Surgery General and also Chief of the Medical Corps.” He said, “I need a good deputy for this Chief of the Medical Corps job, because I just can’t really do both. I need somebody who’s going to essentially run the Medical Corps and I’d like you to do that.”

So, I'm thinking, okay, this is going to be great. I'm going to be short-toured next summer. I'm going to be going to Washington and I'm just going to work. I've got two widowed mother-in-laws, I just PCS'd to San Diego, my wife's got a new job, I've got kids in school, how am I going to do all this? But I said, "Okay."

He said, "I know this is short notice, so take a day to think about it and give me a call tomorrow. Talk to your wife about it and give me a call tomorrow."

I said, "When would I need to report?"

He said, "I really wanted you to report last week, but I'll settle for coming as soon as the GME selection boards are over next week." So, in other words, in about ten days I was going to PCS to Washington.

So, I went home and told my wife and she said, "I'm not moving to Washington. There's no way. My mother's sick, we got all the kids in school."

I said, "I'll call tomorrow and tell him it's a no-go."

She said, "No, no, no, I'm not going, but 'no' is not one of the options on that list." She said, "Your former commanding officer calls you up and pleads with you to come to Washington, there's only one answer and that's 'yes,' so, you're going and we're not, it's as simple as that."

I said, "How's that going to work?"

She said, "It's going to work just fine. You're going to Washington; we're staying here because there's no way we can uproot our family." Now, this was October, so all four kids were in school; her mother's having surgery and my mother's not doing well. There was no way to uproot all those people on that kind of notice. Functionally, it's the

same as getting orders to Afghanistan. You're not taking your family to Afghanistan, so it's the same sort of thing. If you were on a ship and deploying, we wouldn't be getting on the ship with you. So, I called him back and said, "Yes." And so the following week we had selection boards. I picked all the interns and we flew at noon on Friday. At two o'clock in the afternoon my wife and I got in our van and drove across country to Washington. I went to the BOQ at Bethesda, unpacked, and the next day I put her back on a plane to fly back to San Diego. So, that's how I got to Washington. And Higgins pretty much let me run the Medical Corps.

It turns out that most of the Corps Chiefs at the time were heavily engaged in their primary functions-the Nurse Corps Chief was busy running Med-05, so those of us who were the deputy chiefs really ran the respective corps. All of our offices were all in the same spot over in BUMED Building Six overlooking the Lincoln Memorial.

What was the state of the Medical Corps at that point?

The Medical Corps was in a period of great transition. We had the Billig affair, and then we had the standing up of the whole physician assistant's group. Initially the MSC didn't want to have anything to do with them. That whole PA development process was brokered by the Medical Corps, and one of the guys on our staff who was a physician's assistant was helping set up that program. Eventually it moved under the MSCs because if you're not a doctor, you're not a nurse, you're not a dentist, you're in the Medical Service Corps. Eventually PAs became MSCs, but during the two years I was in Washington that whole process of how that was going to happen, the standards and everything else, were developed under the umbrella of the Medical Corps.

And then, of course, you had the largest recall of medical personnel since World War II.

Yes, when Desert Shield started, all of that happened very quickly and all of a sudden people were leaving. I talked to Admiral Zimble and I thought I would go out with the Marines but he said, “No, you can’t go. I need you to take over some additional duties in addition to being the deputy chief of the Medical Corps. You’re going to be the specialty advisor for surgery, anesthesiology and orthopedics because those guys all left.” So I became double-hatted as the Deputy Chief of the Medical Corps and the Special Advisor for Surgery, Orthopedics and Anesthesiology.

That was an interesting time. Due to the recall hospitals were left with a handful of attendings on residents. There is a spot in the law that allows partially trained residents to go forward in contingency situations, but it was determined by the services that the residents would stay for their training, so no residents were sent forward, but most of their teachers were; most of the staff was. And so amongst the people who were recalled, some were recalled to go forward and some were recalled to take staff positions at Bethesda, Portsmouth and San Diego. The only people who stayed behind were the chairmen of the departments and maybe one or two others, but by and large, all the staff left the teaching programs. They all went to the desert and were replaced by Reservists. And the Reservists were called up for themselves-academic surgeons, for the most part, from various universities.

How do you assess how Zimble was doing as Surgeon General during that time?

Zimble for me was one of my heroes. Again, I'm very operationally oriented-that's my north star; so was he. And he made decisions that were absolutely based on what was best to support the war fighters and the medical people who were on the front lines with them. And it's why I didn't go forward. He made the decision that I would be more valuable where I was, and as it turned out, in addition to those duties every morning there was a cadre of deputies that met in the skiff, usually started up about five or six o'clock in the morning, and the first thing we did every morning was get in contact with the CENTCOM guys on the ground and go over all the things that were going on in required support in the front lines, and we were directing from there everything that was going on. We were the background and supported directly a lot of stuff that's not going to be talked about. Let's just say there were a lot of important things that happened at the skiff every morning. That was just kind of how our day started, seven days a week, by the way. On Saturdays and Sundays we were over at the skiff at 0-dark-hundred, just the guys in the desert talking about what they needed, this and that.

Anything surprise you about that conflict? Anything you can think of?

There were some things done in that conflict that were different and yet they were the same. Prior to that conflict we started the beginning of some gender integration amongst the line services. So, women were beginning to get more front line aviation billets and things like that. When the balloon went up, the Marines swapped out all the women who were put in those positons and put men in their places and sent the

men forward. So that experiment that they were beginning to deal with, that got put on hold and they literally swapped women out and sent the guys forward.

This is important culturally because after 9/11 happened the Marines made the decision that if there was a woman in a position, that's who was going forward. They didn't make any last-minute swaps. So, that conflict in Afghanistan was the first time we sent a whole bunch of women forward into front line positions-helicopter pilots, etc. And the farthest forward medical unit was a combined unit that came from Camp Pendleton and San Diego. There was a woman in charge because it was her group, so I had a woman surgeon in charge, and I had a female nurse, and they went as far forward in Afghanistan as you could get at the time. Remember the Marines went into Afghanistan using war fighting techniques that they expected to be able to do when they had Ospreys and Triple AVs and a whole ship-to-objective-maneuver and all that kind of stuff; these were still just PowerPoint slides when I took over as Medical Officer of the Marine Corps in 1998. When the Marines went to Iraq in 2003 they actually executed a lot of those war fighting concepts without the benefit of hardware that they felt essential to do it. So, medical was no exception.

We were talking about a lightning strike of Marine forces moving very quickly, the medical stuff that was in Afghanistan was too heavy. It was kind of traditional fleet hospital type of outfit that you could not move quickly. When we went to Desert Storm/Desert Shield, it took weeks to set up the fleet hospitals. There were people setting up those fleet hospitals for weeks while we were getting the personnel together. I mean, the general that my memory serves as being instrumental in fast-tracking things

that happened between when we went to Afghanistan and when we went to Iraq was General Mattis.[64] In my recollection, he was First MARDIV at the time. And prior to Afghanistan, there was an exercise called Bright Star[65] that was a combined exercise that Mattis was in charge of with us and the Egyptians and during that exercise we deployed a prototype of a Forward Resuscitative Surgical System (FRSS). Mattis was instrumental in fast-tracking the procurement and development of FRSSs so that when Iraq came up 14 months later, the Navy had a full complement of FRSSs, which started a little more than a year earlier with one prototype. That was a major reason why the KIA rate in the war went from 30 percent down to less than 13 percent when the Marines went to Baghdad.

The FRSS concept was one in which the facility would be manned entirely by medical personnel requiring no Marine support, so they'd put it up, take it down, operate all the equipment including generators, etc. It all had to be operated by medical personnel without support of Marines. They had to be able to put it up and take it down in one to two hours. Everything had to fit on a couple of Jeeps and trailers. And they basically could do X-number of procedures over a 48-hour period and then they were done, and then a new FRSS would move in to take their place and move ahead, and

[64] Mattis, James, Gen, USMC. Mattis commanded the 1st Marine Division in the invasion of Iraq in 2003. In retired served as the 26th Secretary of Defense (20 January 2017-1 January 2019).

[65] Operation Bright Star 2002. An international military exercise that took place in October to November 2001. In addition to the United States participants of the exercise included France, Germany, Greece, Italy, Jordan, Kuwait, Spain, the United Kingdom and Egypt.

then they would be moved back to a rear echelon to be resupplied and whatnot. That was the concept and it worked.

This basic concept had existed prior to Bright Star correct? It is my understanding that it grew out of what the Air Force had been doing.

Yes, this is modular, fast-moving capability concept was actually started by the Air Force as they were looking at their needs for setting things up. Their needs were based on needing to have people on the ground for a short period of time at the air head to stabilize casualties as they were being loaded on to fixed-wing for long distance flights, so that was the Air Force's mission. And the Air Force basically told their medical people, "You get one or two pallets and everything you need for this mission has got to fit on these one or two pallets, that's all you get."

So in the 90's, the Air Force developed these modular concepts where everything they would need for that mission could fit on a couple of pallets and could be carried mostly on the backs of the personnel who were going to man these units comprised of like eight to 10 people. Most of the gear that was necessary could be put on their backs, if necessary; it was very austere. But the other innovative part of it was that everything that was in this mobile front-line unit contained equipment that could be modularized and used to create a larger unit. Each one of these units could fit in a couple of Jeeps and maybe a pull-along trailer. But, let's say everything fit on one pallet, if you had ten pallets, and instead of eight people you had 80 people, and essentially the same kind of stuff, but when you put this stuff together you can have a much more capable unit because you had more people and more equipment. But, the stuff for 80

people could be broken down into packages of the most highly expeditionary unit. That was their concept.

For the Air Force, everything is built around what is going to fit on the aircraft. How many pallets and how much does it weigh? So, the Air Force was very heavy in developing stuff that was smaller, modular, lightweight, and could do the job but didn't pick up a lot of room because the Air Force told them, "This is all the room you're going to get. So all the stuff you think you need has got to sit on these two pallets and weigh X-amount."

CAPT H.R. Boman[66] is the name that I most associate with the development of the FRSS.

Yes, H.R. Boman was the father of FRSS and I was the godfather.

I did not know that.

Yeah, nobody knows that because it was never important for me to tell anybody. It's never been important to me to have my name on stuff, not important. I wasn't busy trying to polish my own reputation. What was important to me was listening to Commandant Gen. Hagee[67] saying, "Thank you, Medical Department." These are his words, "The first 100 Marines on the road to Bagdad who made it to an FRSS all survived. That's never happened before in the history of Marine warfare." Now,

[66] Bohman, Harold R., M.D., CAPT, MC, USN. Served with 4th Medical Battalion in Iraq, "The Devil Docs" providing frontline surgery. Bohman was one of several Navy physicians to develop the concept of the FRSS or Forward Resuscitative Surgical suite.

[67] Hagee, Michael, Gen., USMC, Commandant, 2003-2006.

remember, in 1998 these were nothing more than PowerPoint slides. There wasn't even a prototype.

FRSSs are widely considered some of the most important innovations of the Iraq War.

Basic, sort of, modular concept of how you move quickly in supporting a mission. The modular stuff was an Air Force concept. We looked at a lot of that Air Force stuff that they were developing for their missions and when I looked at the slides and looked at what the Marines wanted to do I looked at hospital companies and all the stuff that we had to inventory and said, "This won't work." The Marines are going to leave their deep water support, their LHAs, etc.-remember, I started out on an LPH, so my very introduction to the Navy was based on this amphibious concept. If you're going to position yourself 30 or 40 miles out to sea out of range of shore-based batteries and then hit the objective inland, not bother to build up anything on the beach-remember, all amphibious warfare and doctrine prior to that was establish on beachheads on Iwo Jima, Normandy, Inchon, and then move them inland from their beachhead-ship to objective maneuver. There is no beachhead. You go directly to the objective, and if you start 30 to 40 miles out at sea and the objective was 20 miles inland, then your casualties are 50 miles from your medical support, and there is no beachhead to establish a medical company or hospital company. Not only that, the Marines are going to be moving very quickly. How do you have something that keeps up with it? So, it was that fundamental; this is what the Marines plan on doing. And remember, Ospreys were still on the drawing board at that point. They would replace the CH-46s, but they were

talking about the capability to move equipment and material over longer distances at higher speeds because the Osprey was going to go into a fixed-wing mode.

The Ospreys were supposed to be initially ready around 2005, 2006. In 1998 they were talking about war fighting concepts and whatnot that weren't going to be ready until 2010. Then 9/11 happened, and of course, the bad guys were located in these areas that were not immediately accessible from the sea. They were in Afghanistan and Iraq. To get to those objectives there wasn't going to be a buildup on the sand if you were on a beach. And the reason why the Marines were on the road to Baghdad was because the Army couldn't get there. Remember, it was originally the Army's mission, but the Army had to bring its folks in through Turkey, and they weren't able to do that for a variety of reasons. But basically the mission needed to be accomplished. The Army couldn't get there. The Marines, with their expeditionary mindset, were able to get Marines there and take the mission because the Army wasn't expeditionary enough to do that.

And so the concept was put up on an FRSS and take care of 15 to 20 serious casualties over a 48- to 72-hour period, do all the stabilizing surgery and then you're out-you're out of supplies and material and what not. What replaces you is not a replacement for your FRSS. What replaces you is another FRSS with another team. So, basically you had the FRSS and the people operate maximally for 48 to 72 hours and then you're exhausted and you're taken out and a fresh one was put in. You can go back for X-number of days to rest and rebuild your FRSS and push forward. That was the concept.

The basic concept was you're building something that's going to match the war fighters war fighting. And basically, what we had in inventory was stuff that made sense in Korea and World War II. We hadn't really upgraded since then. The biggest change between World War II and Korea was the helicopter. If you think of M*A*S*H where this primitive bell helicopter would strap a guy on the little outriggers on each side, that was a monumental step forward in terms of battlefield casualty treatment. For the longest time the "Golden Hour" of civilian trauma surgery, and that's ATLS, was considered not to be possible in a military setting until we introduced the FRSS, and that Golden Hour has not only become possible, it's become the standard.

The other thing that changed while I was the TMO was our approach to research because of budgetary curtailments, etc. The Navy basically said, "If we're doing research it has to be something that directly supports an operational mission." So, in the case of medicine, my name was being put in for things like FRSSs and stuff like that. Does the Navy has an operational need to cure cancer? The answer is no. Now, there may be some indirect things, but if it comes to finding the cure for cancer versus finding the way to stop arterial bleeding with a topical product, which is more important on the battlefield? Maybe the cure for cancer as a spinoff of thinking of some biological or chemical weapons, but, when I talked to the basic research guys then I said, "There's three things I need to have in the hands of a first responder that you guys need to develop." And this is very much a concept that needs to be in the corpsmen's pack, or even better, in the pack of a soldier or the Marine, because if you're in a fire fight, this is what needs to happen. First of all, they developed better body armor. So, the other thing

that happened is that we were selecting out more survivable injuries. I mean, injuries to the torso were less lethal because of body armor. The injury to the head was less lethal because the helmets could stop a 7.62 (mm) round, so you didn't get the penetration from a 7.62 round, but you did get a traumatic brain injury from the blast effect, but you survived.

A huge portion of traditional injuries that make you KIA are a lethal head injury, a lethal torso injury, or lethal extremity injury in which you bleed out from a major artery or whatnot. Wearing body armor to the point where you reduce the incidents of torso injuries that are lethal, in a helmet which reduces penetrating head injuries, which are lethal, and if you controlled the initial hemorrhage, you now have a whole bunch of injuries that used to die on the battlefield that you can now stabilize to get to the next level because we've created more survivable injuries.

If you're thinking about extremity injuries, in particular, there's three things that you need. Number one: we started using tourniquets more, but in a hypothetical situation what I need is a patch, something that I can topically put on a wound that would stop arterial bleeding. If I can slap something on, a pressure bandage that has something in it that will make the vessels constrict, it would stop hemorrhaging. That's a winner.

Number two: These injuries hurt like hell. I need something that can stop the pain that can be applied topically that will stop the pain locally and not have a systemic effect. So, it stops the pain but it doesn't knock me out. Why is that important? Because if you're in a firefight and you get one of these injuries, your ultimate survivability

depends on your ability to keep returning fire. You can't return fire if you've got your hand on a wound keeping pressure on it. You can't pull a trigger and keep pressure at the same time. You can't pull a trigger if it hurts so much that it keeps you from doing it. And you can't pull a trigger if the stuff that takes your pain away knocks you out.

And the third thing I need something that will combat whatever local pathogens are, because if I survive the other stuff, I die a week or two later because of infection usually picked up from the soil around me. So, I told the researchers, "I need a three-in-one pack that I can slap on an extremity wound that will stop arterial bleeding without a lot of pressure, that will stop the pain without a lot of systemic effects and has something in it to combat the soil bacteria that's specific to the bacteria of the pathogens that are in the soil that the war fighter finds himself. So, it's got to be genetically engineered specifically because what's in the soil in Afghanistan is different than what's in the soil in Iraq or Southeast Asia. That's the theoretical.

Now, in 2018, we have developed a lot of topical stuff that will stop bleeding, so some of these things are coming to fruition, but again, the FNC-Future Naval Capabilities, -and these research capabilities had to be tied to mission-specific stuff. Researchers would work on something that I just outlined in the concept, because every one of those things has an immediate and direct application to the war fighter, not only saves his or her life, it keeps them in the fight to save themselves and others.

SESSION 4: 12 December 2018

Deputy Commander, Naval Medical Center San Diego

Sir, I would like to pick up where we left off. When we last spoke you had just left BUMED and returned to Balboa to serve as the deputy commander of NMC San Diego.

I finished my tour as the deputy chief of the Medical Corps. I left in 1991; as I recall Zimble[68] was finishing his tour as Surgeon General; I don't think Don Hagen[69] had taken over yet. When I got to San Diego, Halder[70] was the CO and Jack Thomas was the XO. When I came back to San Diego, I became medical director. Subsequently, Ridenour[71] became the commander—which as memory serves it was about 1992 when he replaced Halder. Halder retired and Ridenour took over as CO. Jack Thomas was retiring as executive officer and Ridenour decided that he wanted me to be the executive officer. And then, shortly after I assumed the positon of executive officer BUMED reorganized the enterprise and the hospital became the Naval Medical Center

[68] Zimble, James, VADM, MC, USN, Surgeon General of the Navy, 1987-1991.
[69] Hagen, Donald, VADM, MC, USN, Surgeon General of the Navy, 1991-1995.
[70] Halder, Robert, RADM, MC, USN, Commanding Officer, Naval Hospital San Diego, May 1989-May 1992.
[71] Ridenour, Richard, RADM, MC, USN, Commander, Naval Medical Center, San Diego, CA, 1992-1993; Deputy Surgeon General, Bureau of Medicine and Surgery, Washington, DC, 1993-1994; and Commander, National Naval Medical Center, Bethesda, MD, 1994-1997.

San Diego. Remember the naval hospital was the vestige of the HPCP situation. Prior to HPCP, the major medical centers like Portsmouth, Bethesda, San Diego, Oakland were medical commands all of which had flag officers in command. The non-medical centers were hospitals; that all got changed when HPCP came along and everything was a hospital before they were medical centers. So, Naval Hospital San Diego reverted back to Naval Medical Center, San Diego. If you look at the history of the hospital it has gone back and forth over 100 years as to when it was a hospital or a medical center. Under the medical command model, the number two person is not an executive officer, but rather a chief of staff or deputy commander. So, if a flag officer is in charge of a staff, then his number two person was the chief of staff. If it's a base, then the number two person is the deputy of the base or a deputy commander, because flag officers are not commanding officers. Flag officers are commanders, and therefore the person who is their right hand is a deputy commander, not an executive officer. So the four major academic centers[72] reverted back to medical commands, and the number two person reverted to deputy commander vice-executive officer.

So, I returned to San Diego as the medical director, became the executive officer, and then the deputy commander under Admiral Ridenour.

Did the duties of the position change as your title changed?

Yes, because the position of a deputy commander, or chief of staff, carries more responsibility because you are identified as someone who is the right hand of a flag

[72] Bethesda, MD, Oakland, CA, Portsmouth, VA, and San Diego, CA.

officer or general officer. As the executive officer, you are the number two person in the hierarchy, but you don't work directly for a flag officer. It's an important distinction. The flag and general officer community has an entirely hierarchal organization that is based on tradition, but is distinct from the chain of command for non-flag officer positions. As I said, a flag officer who's in charge of something is a commander. A non-flag officer who's in charge of something is a commanding officer. And the Navy, as much as anybody, is a stickler for those kinds of distinctions.

What was the state of Balboa when it switched back to becoming a Medical Center?

In terms of the functionality and the care that was being delivered it was seamless and transparent. The changes in the name and whatnot were largely a front office issue. To the average patient, the average doctor/nurse/corpsman, it didn't make a functional difference. It might have changed the patches they wore on their uniforms, but other than that there wasn't a real distinction.

But what it did do is it alter the relationship of the Medical Center within the San Diego community because the head of the command was now a flag officer, and therefore all the things that involve flag officers he goes to. In the old days, he would be going to the things that involved commanding officers, and it was up to somebody to figure out that*, "*Oh, there's that flag officer over there*."* But as a command, and as a flag officer in charge of the command, that puts you on the same footing as all the other flag officers in the San Diego community who were in charge of commands. It also meant that the deputy commander was in the same league as chiefs of staff and deputy

commanders throughout the rest of the San Diego community. That was a very important move in terms of putting the Medical Center in the center of communication vis-a-vis the larger Navy community. In that sense, it was much better because you're much less likely being engaged first-hand in the normal things that flag officers, chiefs of staff and deputy commanders are engaged in if it means you're getting information and front-line communication and front-line relationships for the line community that you ultimately serve.

In my case, Admiral Ridenour made the decision that since I was a deputy commander I should be wearing the aiguillettes or "rope-a-dopes," which all deputy commanders and chiefs of staff wear. If you see a captain who's got those on you just count the number of strands and know whether he works for a two- three- or four-star. If it's a lieutenant you know it's a flag lieutenant.

From the standpoint of tradition and culture, recognition and communication, it makes a difference. When I had those on and would go to Medical Department meetings anybody in the Medical Department knew instantly that I was the deputy who worked for one of the flag officers. I mean, it's a visual distinction. Your approach to a lieutenant or a captain wearing the aiguillettes compared to anybody who doesn't have them is different. You know that that person speaks to a position of flag and general officer rank. And by extension, as a general rule-not 100 percent foolproof-but a general rule, a person wearing those is not a bozo. You can take that to the bank pretty much 100 percent of the time. So, your interactions with that person is also different. You're on-guard not to say stupid things and what not.

You mention Admirals Halder and Ridenour. I would imagine their leadership and management styles were different. What do you recall about each of them?

Actually I knew Admiral Halder going back to the Camp Pendleton days. When I was at Camp Pendleton, Admiral Halder was an ophthalmologist and was head of ophthalmology. He was a captain at a time when I was a general surgeon there. And then Admiral Halder left and went on to his career. So, when he came to San Diego as the commanding officer, I knew him from my Camp Pendleton days. And in fact, Admiral Halder-if memory serves right-was not only the head of ophthalmology, I believe he was the director of surgical services. At any rate, my recollection is Halder found out about my experiences in the civilian sector and tasked me to run a committee. One of the problems that the hospital at Camp Pendleton had was a completely out of control, poorly regulated forms control process. This was back in the day of paper records and before the adoption of electronic forms. Whether it's a patient record form or an operating consent narrative everything had a form number. I think as Halder took over he discovered that the old forms control process was a mess and so it not only needed to be brought into compliance with respect to BUMED, it needed to be in compliance with respect to Joint Commission standards. Long story short, he put me in charge of that committee, which was the first non-clinical responsibility I had at the hospital. It turned out to be an enormous mess. At the time the forms control meeting was a sleepy committee that met once a quarter. The first thing I did was change the standard to once a week and we were going to meet once a week until we got that stuff under control. My upbringing was one: whatever opportunity you're given you have to make

the most of it and you don't get to pick your opportunities, they pick you. I was given what would appear to me from my civilian experience an absolute mountain of bad things. And here I was a new, young naval officer. And I said, "I got to get this fixed as quick as possible." So, that's how I got to know Admiral Halder in the early days.

It's actually interesting that you, Halder, and Ridenour all have that experience with the Marine Corps. Certainly, Ridenour would proceed you as the TMO, but what sort of leader was he when he was at San Diego?

Halder and Ridenour had different personalities. Halder was an ophthalmologist, a surgeon. Ridenour was a psychiatrist. This was back in the day when we were all going through the Myers-Briggs as part of leadership training.[73] All officers in command were going through Myer's-Briggs training. Ridenour, of course, was a psychiatrist, and he thrived on having what he called a "balanced approach to things." He knew his strengths and whatnot as a psychiatrist and he specifically surrounded himself with people who were not like him. He put me in that position of executive officer because we got along very well, and it was kind of Yin and Yang [relationship]. I approach things from a surgical perspective and he approached things from a psychiatrist's perspective. He also had a lot of extroverted tendencies; most psychiatrists are more introverted, but we got along very well and I thought he ran a very good command. He obviously had a very good appreciation for people, but also had the experience of having been a TMO which really roots you in your ability to practice medicine in the Navy. We've had that

[73] The Myers–Briggs Type Indicator is an introspective self-report questionnaire with the purpose of indicating differing psychological preferences in how people perceive the world around them and make decisions.

experience with the Marines, who are a huge part of the population that we take care of, particularly on active duty, and particularly when it comes to combat injuries. So, when you're been in that TMO position where you've had experience along the way working with the front line Marine operation issue, first-hand experience at the dual perspective patient population that is a part of Navy Medicine, that is not a part of Army or Air Force Medicine.

Operation Provide Promise

As Deputy Commander did you have the collateral duty as the Commanding Officer of the Fleet Hospital?

Yes. At the start of the Gulf War the Medical Department was organized in a way that was appropriate for World War II, Vietnam, etc., and the fleet hospitals were part of that. Fleet Hospital Five out of Portsmouth and Fleet Hospital Six out of San Diego were both sent to the desert and it was a huge evolution to get them set up. The Seabees had to prepare the site for putting up all the facilities-tents, and whatnot-and it took weeks of doing that. And then the personnel went over and occupied it.

The best way to describe fleet hospitals at the time is to think of them basically like a M*A*S*H Hospital. If you look at the *M*A*S*H* movie or TV show it was very much like that-a grouping of tents and other structures. They were big; they were heavy, and they were supposed to be a front-line field hospital set up directly in support of the Marines. The fleet hospitals were not designed to support the Navy. They were designed to support the Marine Corps. And the people who staffed them were typically

assigned to hospitals when fleet hospitals weren't deployed somewhere. So when the fleet hospital was deployed somewhere, the personnel from the hospitals and clinics left those hospitals and clinics and went forward to staff the fleet hospitals. That process hasn't changed and that's the same for the Air Force and the Army; they have their own version of deployable billets where people were back in Travis or Brooks or wherever, and the Army/Air Force goes forward with their forward deployed units and people get jerked out of those stateside hospitals to command them. So that's the same.

What changed with the Croatian mission was that Fleet Hospital Six was assigned to San Diego; Fleet Hospital Five was Portsmouth. I remember those two distinctly. So, the Croatian mission was a UN peacekeeping mission. For years [Josip] Tito[74] was the only thing holding together the tribalism of what we then called Yugoslavia. Historically, Yugoslavia didn't exist before World War I. It was a bunch of tribal organizations based on ethnic and religious histories in the Balkans. After World War I, Yugoslavia was created and composed of all these ethnic areas-Slovenia, Croatia, Serbia, Bosnia, etc. When Tito came to power, while he was a communist, he was what I call a "capitalistic communist," and he wasn't as much as a hardliner as some of the Russians. Despite the various ethnic groups the one thing that was forbidden in Tito's Yugoslavia was nationalism. You could have pretty liberal politics, but the one thing that he absolutely would not allow was any of the various tribal groups espousing their nationalism. If you wanted a quick trip to the slammer and the gas

[74] Tito, Josip (1892-1980). Communist leader and president of Yugoslavia from 1953 until his death in 1980.

chamber, try your ethnic stuff. So, that's how Yugoslavia was run. Tito died in 1980 as I recall and didn't have any kind of successor; he was an absolute autocrat, like most of the communist leaders in the Soviet bloc nations. When he died, all of a sudden there was this power vacuum that had been dormant since almost the turn of the century. All the different countries came apart, so Slovenia, Croatia, Bosnia, Serbia-they all decided they were going to become their own independent country and civil war broke across Yugoslavia. And that's when the United Nations started their peacekeeping mission. Slovenia was the first to break loose from "Yugoslavia," but Slovenia is a relatively homogenous. Over ninety percent are Roman Catholic and ethnically they are relatively homogenous. When Slovenia left Yugoslavia, the armed fracas lasted just a few weeks and it was over and that was that. There was really nobody to fight about it within the country, everybody was in agreement. Croatia was the next big spot but Croatia was different. While Croatia was predominately Roman Catholic, it had a significant part of the population that was Orthodox Christian and Serbian; while the majority of Croatians were Roman Catholics, they were the significant minority in the eastern and southern parts of the country that was Serbian Orthodox, and so they got into a real war with both sides fighting. Bosnia was even worse.

So the first conflict was in Croatia, and then Bosnia. Bosnia was a tripartite ethnic society with Bosnian Croats who were Roman Catholic, Bosnian Serbs who were orthodox, and Bosnian Muslims. The largest ethnic group were the Muslims left over from the Ottoman Empire. Now, ethnically, they're all Slavic, so whether you're a Croat, a Serb, or a Muslim, you were Slavic in your ethnic orientation. None of the three major

groups had a majority in Bosnia. The Muslims had a plurality; they were the largest ethnic group, but nobody had over 50 percent. So it was just a real mess. But that's what the UN mission was designed for.

When it first started, the U.S. agreed to provide medical support in Zagreb on the outskirts of the civilian airport where the U.N. set up its logistics headquarters. So, the administrative site of the U.N. mission in Croatia was in downtown Zagreb, but the execution piece of it was at Camp Pleso at the Zagreb Airport. Part of that site was a UN mission, part of it was Croatian military, and part of it was the civilian airport. They were separated areas, but it was all the same piece of real estate, so to speak. Kind of like Joint Base Pearl Harbor-Hickam, where Hickam Airfield is right next to Honolulu Airport and they both share the runways. Similarly, when planes took off at Zagreb they would use the same runway. Sometimes it would be a UN plane; sometimes it would be Croatian Airline; sometimes it would be the Croatian military. It was that kind of situation. But on the ground the areas were separated and to get from Camp Pleso to the civilian airport you had to drive to it in a roundabout way because you had to leave one perimeter area and drive all the way around to the other perimeter area on the other side. You couldn't walk to it. It was geographically a large piece of real estate and it had its various functions.

Initially, DoD decided to staff the U.S. military medical mission with Army units controlled out of Landstuhl.[75] The first year the Army supplied medical units that were controlled by Landstuhl but may have been taken from various and sundry Army units

[75] The 212th Mobile Army Surgical Hospital (MASH) deployed to Zagreb, Croatia in November 1992.

all over the European theater. Each iteration was six months. The third iteration was done by the Air Force[76] and that unit was homebased in Lakenheath, England. When we took over the mission had been in existence for about 18 months and had been staffed by European and U.S. military. So we were the first Navy unit. We were also the first unit to come from CONUS, so it was a whole lot different than what it had been prior to our coming here.

When Ridenour called me up I think it was right after the holidays and he told me about this mission in Croatia. The first thing I did was try to figure out where the hell Zagreb was. I didn't know much about Europe and I'd never been stationed there. I knew that we had some activities in Italy, but frankly, although I knew where Yugoslavia was, I didn't know where Croatia was at the time. And I didn't have the intimate knowledge of Croatia, Slovenia, Serbia, or Bosnia. Ridenour told me about it and that the six-month mission was going to start in March and the Navy Surgeon General decided that it was going to be a composite fleet hospital from the West Coast, with San Diego as the lead and components from Camp Pendleton, Oakland, Bremerton, Whidbey Island, Twentynine Palms. All the West Coast hospitals were going to commit personnel to this composite platform.

At the time in each command there were two non-deployable billets—the commander and deputy commander or CO and XO. When Ridenour told me about the Zagreb mission, I assumed he was telling me this because I was a deputy commander

[76] The 48th Air Force Transportable Hospital (ATH) was based in Zagreb from October 1993 to March 1994.

and obviously I would be in charge of putting this together, and then at the end he says, "You're going to command it."

"Well, sir, I'm the deputy commander. That's a non-deployable position."

He said, "Not anymore." So, I was a crash test dummy for that. And actually, subsequent to that Croatian mission, BUMED reorganized all the fleet hospitals so that if your facility had a fleet hospital the executive officer would be the CO of that facility. And that became the way fleet hospitals were organized thereafter. So when we were relieved by Fleet Hospital 5, Gregg Parker, who was the deputy commander at Portsmouth, was the CO of Fleet Hospital Five.

Prior to the Croatian mission the people who staffed fleet hospitals came out of various places; there may have been a designated CO from each fleet hospital, but it wasn't the executive officer of the hospital.

Did Ridenour tell you why he selected you for the mission?

I have my own suspicions. This is only speculation, not confirmed by any direct knowledge or conversations with any of the principals involved, but at the time that the Croatian mission came about decisions were being made about who the next surgeon general was going to be. Hagen served as Surgeon General from '91 to '95; in '94, the shortlist for the next SG was starting to be compiled. Ridenour and McDaniel,[77] then commander at Portsmouth, were felt to be the two main frontrunners. As it turned out, when the decision was made Koenig was selected with the scuttlebutt being that

[77] McDaniel, William, RADM, MC, USN. Commander, NMC Portsmouth, VA, 1992-1995.

Ridenour's backers and McDaniel's backers were at loggerheads. There were always sponsors, and then Koenig, who was not mentioned at the time as being a frontrunner at all or even in contention, was selected and it was a surprise. People always had talked about Ridenour or McDaniel as the next SG. The scuttlebutt was that Koenig was a compromise because the decision couldn't be made between McDaniel and Ridenour.

In 1994, after his tour as Commander of Balboa, Ridenour was the deputy surgeon general. He and Hagen decided that the first fleet hospital going to Croatia was going to be a West Coast hospital. Obviously Ridenour knew me well because I was his deputy commander. I wore his aiguillettes so, I'm virtually 100 percent sure that was something he personally worked out with Hagen that I would be in charge of it; he wanted somebody there that he had confidence in. That was pretty much it.

You have to remember that the mission in Croatia was a major positive coup for the Navy. We know we did the mission well; we did the mission differently than the European units, and we instituted some things and upgraded some things simply because the mission was now being done by a unit from CONUS as opposed to one from Europe. So we put all kinds of things in that were different.

At the time this was going on, the United States didn't acknowledge that it had a significant role in anything going on in the Balkans other than the military medical mission. Things that we were doing downrange in Bosnia and Croatia were line oriented-which there were substantial things going on-were not actively acknowledged. They were mostly clandestine, black, unpublicized operations. The medical mission in

Zagreb was publicized; it was well known. In the United States the PR on that was significant, because again, this was not a new mission when we took over, but it was a new mission as far as most of CONUS was concerned. The previous 18 months had been done by Air Force and Army units out of Europe. When we left to go it was a big deal, and not only was it CONUS, it was West Coast CONUS. The logistics of getting us there and everything else was big news. And because we were a composite from all the various naval hospitals and clinics on the West Coast it was a major news item from every local newspaper from Bremerton to the Bay Area to San Diego. Remember, also, nobody had deployed significantly, or at least in a public way, since Desert Shield/Desert Storm. So, this was a big hoo-ha from a PR publicity standpoint. And BUMED decided they would make the most of it. They weren't shy about the fact that we were going, and they weren't shy about publicizing it. I think for the European units this was something they did well, but it was more of a burden for them. They didn't wake up at night hoping they could go down to Camp Pleso. It wasn't at the top of their radar as to what they wanted to do with their European tour. And in fact, we discovered that they had a very generous weekend leave policy. They were deployed, but all their personnel routinely went home on 96-hour liberty at least once a month every couple of months. They would go home back to wherever their base was and visit their families. The same thing happened with the guys in England.

So they were forward deployed, but they still remained much more intimately attached to their home bases, and if somebody got sick or whatever, they sent them back and somebody else would be get sent forward for two weeks and take their place.

So, it wasn't the kind of a hardship deployment that we think of in the Navy Medical Department. For us this was different. This was a deployment. We were leaving for six months and we weren't coming home. And in terms of distance, we were leaving from the West Coast and that's a hell of a long way; it's like going to the Middle East or what not.

How was the hospital organized to meet this mission?

We had to organize in a way that the European units didn't have to organize. And we had an ombudsman support. I had to sell this to all the [West Coast] hospitals. I wasn't the only guy who didn't know a damn thing about Croatia, nobody else did either. So number one they said, "Okay, Croatia," and the second question was, "Why the hell is this a Navy mission? It's in a country where there are no Marines involved so why are we doing this?" There was a whole educational component of this for all the people who were being tasked, and it had to be done quickly. I figured out who my command task was, and one of the things we did early on is go to each of the various component commands like Twentynine Palms, Oakland and Bremerton and held town halls about the mission and what each hospital commands were going to have to supply. And of course, when we came to town it was a big news items for the local newspaper. By the time we actually deployed, this was something that was big news in all the West Coast media. People knew about it. Every time we went to commands, every place we went to the local TV showed up and interviewed us. I mean, it had a much higher profile than the mission had in the previous 18 months.

Ridenour was intimately behind that. These were Ridenour's people-follow what I'm saying? I think it was not a mistake or a coincidence that the follow-on was out of Portsmouth. It wasn't out of Bethesda, it was out of Portsmouth, and they were all McDaniel's people, if you will. It was close to the fleet hospital. There was a real subliminal competition between Ridenour's fleet hospital and McDaniel's fleet hospital. Remember I said Ridenour and McDaniel were the scuttlebutt front runners to replace Hagen? So, to some extent we were a proxy. It was not only a mission, but we were a proxy to those individuals. So, that's Fleet Hospital Six and all the things that we did was a direct reflection on Ridenour. That kind of stuff doesn't get written down. That's not going to get written down. I don't know how much you can use, but I'm telling you, that's the way it was.

The turnover between us and the Air Force Hospital was quite unique. And like I said, we were a CONUS based unit. I flew over there with my command master chief and my XO about six weeks in advance of when we were going to go. We met in Naples with General [James] Jones,[78] who was the one-star commander in charge of that Croatian mission. Afterwards we went to Croatia and had a preliminary interaction with the guys at Camp Pleso, and then we went back and then we went to training. We had a period of about a month or so before our deployment when everybody went to the Fleet Hospital Operations Training site in Camp Pendleton and took all those composites from those West Coast commands. I forget how long it was, I want to say it

[78] Jones, James, GEN, USMC. Chief of Staff, Joint Task Force Provide Promise, 1992-1994. Later Commandant of the Marine Corps (1999-2003) and Commander, U.S. European Command (EUCOM) and Supreme Allied Commander Europe (2003-2006).

was at least three or four days, maybe as long as a week. And we nailed it as a command unit. Everybody left that site and went back to their respective commands understanding that they were part of Fleet Hospital 6. And they were going back to their commands forever changed. They came here as some kind of augmentee from Bremerton or Oakland and they left as members of Fleet Hospital Six. They went back to their original command solely for the purpose of getting things organized securely back at their home base so that they could deploy in a few weeks.

When they went back, most of them also went on leave. A lot of people went back and part of that time period when they were between training and deployment, they took leave because unlike the European units, you weren't coming home. To the standard Navy corpsman, you weren't coming home. There might be opportunities where you might meet a loved one in Europe. I had met my wife and daughter in Switzerland before for four days. Similarly, in Vietnam I met my first wife in Japan for five days, and that was very common. You'd put into a port and wives would fly over to meet their husbands for a few days in whatever port you were in if you were going to be there for an extended time. So doing that wasn't unusual. That happened a lot in the Navy.

For the large majority of the population, they were gone for six months; they were going to see their loved ones. They established new ways to communication. We

established what now would be the forerunner of "United Through Reading"[79] where parents videotaped reading to their kids. We instituted the paper version of that with a pre-practice program that a service member could write home to their kid and their kid had a composite package. It was a standard deployment for us. We weren't going to slip home for 96 hours to see our loved ones. But Germany and Austria weren't far away and the ability to get back to Germany was pretty easy. For that matter, if you wanted to meet your family, they could drive to Croatia. They could drive to Zagreb and stay in a hotel in downtown Zagreb for 72 hours.

That's a little surreal when you consider it's a war zone.

The city of Zagreb itself was less of a war zone. The contested areas in Croatia at the time were further south. For the most part, Zagreb the city, which was fairly north in Croatia, was out of the range of missiles. The airport, Camp Pleso, was kind of on the edge of missiles being able to be reached. We could be fired upon, and the previous unit had been fired upon. We had bunkers and places to go to if we were under attack, but the city itself was pretty normal. If you went to Zagreb itself, there was less evidence that there was a war going on-nobody was shooting. There were obviously vacant areas that were roped off where there were still mines active. You could see destruction of some buildings and what not, but for the most part, when we got there in the spring of '94, there really wasn't any active fighting going on in the city of Zagreb itself.

[79] Founded in 1989, United Through Reading connects military families who are separated —for deployment or military assignment—by providing the bonding experience of shared storytime.

How long did it take to get the fleet hospital fully operational?

Remember, the Army and the Air Force had been there before us so there was a medical compound. One of the things they had done, which was actually creative, was to situate their functional components like tents and CONEX boxes in a couple of empty hangars which protected them from the elements. When you went to operate or to an ICU ward it was inside of a hangar.

When we arrived it was a full-up command. Aside from the medical personnel I had a bunch of non-medical components like a fire department and Seabees who constituted my public works. I also had about 25 or 30 Marines who were part of our security detachment. They were all part of my command and we trained together and, with the exception of the Marines, all lived together. The Marines were bivouacked in an area next to but separate from the medical personnel. And the reason for that is they needed to be able to get to fire control positions and defend the perimeter quickly. I didn't want them inside because if something went down, they needed to roll out of their area immediately into the perimeter.

The Seabees got there and they are artisans. The first thing they did was upgrade the facilities, because as they put it, it had looked like a shanty town.

So, we were in charge of our compound. The overall contingent that was in charge of logistics were the French. Remember, this was a U.N. mission, so operationally we were under the U.N. command as were all the countries. Administratively, we remained under U.S. command.

In March, we had a change of command and once both units lined up-Mike Boorda[80] officiated it as his last official act of CINCUS NAVEUR, and he left shortly after that to assume his duties as CNO. One of the things that I'll always remember is the personal time he took with me and my command master chief. When the ceremony was over and he was heading back to Naples and was within a week of flying to Washington, he personally mentored me and my master chief on what to do, what not to do, and what to look out for. This mission was we had a coalition mission, so in addition to whatever's going on with the Navy we were with over 20 different countries and there was a multi-cultural aspect. Boorda had asked me what I was going to do when they start dancing together because the Navy has the strictest fraternization rules of any of the services. Fraternization rules not only exist between officers and enlisted, but between senior enlisted and junior enlisted. There's a line in the sand between chiefs and E-1s to E-6s. We had a club, but it was an all-hands club, similar to the TV series M*A*S*H. We had one just like that; and it had a lot of young women between the ages of 20 and 30. The biologic soulmate for a woman between 20 and 30 are men between 20 and 30. The majority of men between 20 and 30 are enlisted. The majority of officer males between 20 and 30 are married, so most of the single males between 20 and 30 are enlisted, just like on M*A*S*H. But what are you going to do with fraternization rules when you've got an all-hands club and a 23-year old nurse who wants to dance or have a drink with somebody and that somebody is an HM3? That's a real thing, okay. Just

[80] Boorda, Jeremy Michael (1939-1996). Chief of Naval Operations, 1994 to 1996. Prior to this role, Boorda served as Commander in Chief, Allied Forces Southern Europe (1991-1994), with the additional duty as Commander, Joint Task Force (1993-1994).

like it is on M*A*S*H, and as it is today. Everybody's living together on a ship or a base so that dynamic hasn't changed. If you are a young woman officer in the military, from a numbers standpoint, it's much more likely that your male social mate isn't going to be an officer; that's always been a problem. It's just a numbers game. And Boorda said, "It's going to be a problem and you're going to have to deal with that." And I did. I had some incidents and they all got dealt with.

On *M*A*S*H*, the commanding officer is in the club, but he's rarely there when the club is being closed. So you go to the club, but you go to the club early and you're never there when the club closes. The XO and the master chief are, but if something comes up that's really a problem, you don't want to be there and actually witness it because you're the one that's going to have to decide if it comes to an NJP.[81] You're the one who's going to have to enforce the rules and regs ultimately. Like any other commanding officer, I had NJP authority so if someone needed to be disciplined I didn't have to send them someplace. I dealt with them. So, Boorda was giving us intimate mentorship on how to function as a commanding officer and a command master chief as he was leaving to become the CNO. Those are priceless moments.

Croatia was a very different mission in that respect from the European guys. We had-of course the Air Force, they do a lot of morale and recreation; MWR for them is at the top of the list. So they had an MWR crew and we went over and saw that. That's

[81] NJP (Nonjudicial punishment). Leadership tool providing military commanders a prompt and essential means of maintaining good order and discipline. NJP is permitted by Article 15, UCMJ (Section 815 of Title 10, United States Code) and is governed by Part V of the Manual for Courts-Martial and by service regulations. NJP proceedings may be known by different terms among the Services, such as "Article 15," "Office Hours," or "Captain's Mast," but the purpose of NJP, and for the most part its procedures, are common among the Services.

kind of an afterthought for most Navy units, but when we came back we decided that we were going to going to have some organized MWR activities because Camp Pleso is part of the airport geography in Zagreb, but it's a real camp. You can't freely go from one place to another. If you go into a Croatian military part, there's a perimeter for that. There's an access point and if you don't belong there you can't get in. You couldn't get into Camp Pleso until you belonged there. When you left and went out into town and went any place other than Camp Pleso, there were rules of engagement about what you could and couldn't do, who you could and could not be with, which was an issue. For example, I like to swim and I got permission to go downtown to the major swimming facility in Zagreb, which was an Olympic-sized pool. Even though the war wasn't in Zagreb City at that time, I always went with my body guard. There was a staff sergeant in the Marine Security Detail who was actually born in Croatia. He came to the United States when he was a pre-teen, so he was fully fluent in Croatian. I never stepped outside Camp Pleso without him. When I went to go swimming or I was going to ride a bike it was always with him. Any place we went he never let me go into a room until he swept it for booby traps and what not. He was sort of my "Ninja bodyguard." His shoelaces kept his boots on but they could also be unwound and do various things. More than one way to use a shoelace, I'll put it that way.

Zagreb itself had pretty much gotten back to a civilized posture; when we came in and we found out that within 96 hours there were a lot of places you could get to like Budapest, Venice, Salzburg, and parts of Munich. And if you went north and east you got into more civilized areas; there was no war north and east of Zagreb. The further

south you went, or the further southeast you went, the more you got into trouble. The only McDonald's in the area was in Ljubljana, the capital of Slovenia, but that was, distance-wise, like driving from San Diego to Los Angeles, so it was pretty close. And people would get an 8-hour pass to go to Ljubljana just to get a Big Mac.

BUMED provided us a civilian MWR officer. She was like a tour guide and her whole job was putting together recreational programs so that when we were not actively engaged in the mission we could safely do things like go to activities like the opera in Zagreb. I had a liberal policy whereby everybody had a 96-hour liberty once during the six months, and once a month everybody got a 72-hour; every week somebody was off on a 48. Our MWR officer arranged tours and itineraries of what to do and where to go if you had a 72-hours. On my 96 I flew to Zurich and met my wife and daughter. And then they flew back to the U.S. and I flew back to Zagreb. Other people would go to places like Prague or Budapest. So during that time, in addition to being in Zagreb, I learned a lot about the city. I personally went to Budapest, to Venice twice, went to Salzburg, and to the resort area of Ljubljana, Slovenia.

As CO of this enterprise what were your biggest challenges?

I had a big challenge with fraternization. I'm not going to go into all the details, but individuals were held accountable for the things that they did. Everybody I held accountable was given an opportunity to make amends but it didn't end well for repeat offenders and a couple of careers ended there in terms of their ability to be promoted. That's part of being a CO. If you talk to any commanding officer, any commander that is something they are going to have to deal with. The fraternization rules haven't changed

because we've gone to more of a gender-neutral Navy. While everyone likes to think that the fraternization rules are sexual and what goes on between men and women, it really isn't. It's really about what goes on between people who are of certain ranks, and the basis behind it is that if you have undue familiarity, then that leads to a situation which breaks down good order and discipline. A more junior person seen to be in a position of favoritism from a more senior person and not based on their performance but based on a relationship is an undue familiar relationship. So contrary to popular belief, the unduly familiar relationship is not gender or sexual based. It's based on rank, and so a male chief can have an undue familiar relationship with a second- or third-class that has nothing to do with sex. It has to do with whether or not that person's getting leave, for example, that's different than all the other E-4s and E-5s get.

So every CO has to deal with that. Dealing with it in a forward position is really what Boorda was saying; it wasn't like that sort of stuff didn't happen back home because it does, but you're not going to be back home. You're in the middle of a war zone and you're in a coalition situation where the relationships amongst the different cultures is different. And let's face it, if you're a 24-year-old average looking female back home with an average social life and you're now coming to a forward position where the numbers are such that you are now a goddess amongst all the males. The ratio is ten to one. Not only are you sought by all the horny guys in the unit, you got all the horny guys from all these other foreign units, from all these foreign units. I'm not being sexist, I'm just explaining reality. You think it gets interesting at our all-hands club wait until you go to some of the clubs of the other contingents. Go to the Danish club, or go to the

Swedish club where fraternization is an entirely different cultural dynamic, and there's liquor everywhere. Everybody's club serves liquor, so whatever discipline you have gets attacked by whatever you're drinking. So it was interesting in that respect.

As the CO you've got to be fair and consistent. The most important thing for any commanding officer is consistency. Favoritism often arises because you're just being inconsistent. You don't intend to be that way, but you are. You got to be consistent and you have to conduct yourself in a way that no one can accuse you of favoritism.

You talk about your own personal conduct as a commanding officer, you've got to be the equivalent of a Mother Theresa or the Pope. You can't be a party to looking at anybody; you can't be a party to jokes. You don't have to be a stick in the mud, but you have to establish personal conduct because if you don't, you have no credibility for holding anybody else accountable. You know, I've never been a player, but that was an issue. When I went to the club for a couple of beers and talked to the troops and what not, I was usually out of there between eight or nine o'clock at the latest. I was never there past nine o'clock at night. And my XO[82] was usually gone by then and he didn't close the place either. He always designated somebody as the designated observers. There was always a chief or somebody who was there if something went down that was a credible witness to something. But the two of us, we didn't get that. How else are you going to try something? You're not going to try it when the commander or the CO is sitting there. You aren't stupid. And generally speaking, individuals who wanted to push

[82] Wright, J.A., CAPT, MSC, USN

their borders tended to come to the club after I was gone, but that's the dynamics of all that.

Medically, what sort of issues came up for Fleet Hospital Six?

The medical side was incredibly challenging because from a functional standpoint, within the Croatian theater we were the most comprehensive military medical facility that existed anywhere in Croatia amongst the UN forces. In peacetime, Yugoslavians were good medical people. They weren't bozos. They were well-trained, very competent people. That competence, and whatnot, gets degraded by war. As I said, Zagreb had essentially returned to a peaceful, peacetime existence, so their major medical centers within the city were pretty much back to normal and comprehensive; but they weren't part of the UN peacekeeping mission for the most part. So casualties that occurred in Croatia and in Bosnia were initially treated by medical battalions from a variety of countries like the Norwegians, the British, Jordanians, Pakistanis; everybody had the kind of MED battalion that would minister to their particular forces. When the Pakistanis were doing guard duty somewhere in Bosnia for example, they had their equivalent of a MED battalion with them. Obviously, there's a lot of different capabilities, and I learned, or came to appreciate the fact, that there were three levels of care, and that depended on whether or not the contingent was First World, Second World, or Third World.

First World countries like the U.S., Canada, the United Kingdom, France, Germany, and the Scandinavian countries were generally speaking very capable. The other thing was Zagreb was pretty far north in the country and distance wise, the transit

time from Bosnia and the southern parts of Croatia were hours. If you weren't flying them it could take six to eight hours to get somebody from Bosnia to Zagreb. It wasn't like there was a super highway that you could drive over with nobody messing with you. It was a war zone. If you go back to the TV series M*A*S*H and sending somebody to Seoul, Korea from the unit-you can get them there, but you weren't on a super highway and people might be messing with you along the way. The other issue we were facing were there were landmines. The whole country was mined. That's something we don't appreciate in this country is how extensively some countries are covered with anti-personnel mines. And particularly if you're losing a war and retreating, you leave mines because that's the ultimate retribution. You may have to give up that ground, but you can still inflict hate and discontent by leaving mines everywhere. Even in the city of Zagreb there were places that were roped off because it was still an active minefield. Camp Pleso was located next to an active minefield and there were signs that said, "Don't run here," basically. Every now and then there'd be an explosion that would go off in the middle of the night when some animal stepped on the mine. So, the entire time I was in Croatia, I can tell you literally, I never stepped on the grass.

Did the hospital receive landmine casualties?

Absolutely. At Fleet Hospital Six we had the largest mine injury experience of any medical unit since Vietnam. We cut our teeth on that; we had a lot of things going on with people with mine injuries downrange and we developed an incredible expertise

dealing with mine injuries. My orthopedic surgeon, Dana Covey,[83] did all kinds of innovative work treating mine injuries that he wrote about extensively. He became, and still is, an orthopedic expert on mine injuries. Of course, after 9/11 he obtained a lot of experience with that. But remember, Operation Desert Shield/Desert Storm happened so fast, we didn't have a lot of corporate knowledge coming into Croatia. So, we had casualties, but like I said, in terms of numbers I believe that we had one of the largest experiences since Vietnam in those six months, so that was interesting and intriguing.

Going back to how you take care of people depended on what contingent they were in. First of all, they had to survive the "will to live" test. So wherever they were injured, they had to survive some sort of basic stabilization and then survive the trip over land or by helicopter-occasionally fixed-wing, but not usually-that would get you to our place in Zagreb. We did things that were far more comprehensive than a typical expeditionary hospital. For example, we didn't have any radiologist with us. That wasn't a big deal because most clinicians have to be able to read X-rays in their field as good as or better than any radiologist. But, we had what-at the time-was innovative technology and the ability to send the X-rays that we took and get them back to Balboa by satellite. In fact, I had an officer who was in charge of that whose clearance level was above top-secret because he was able to interact with the satellites directly. And you know how he did that was-you didn't know. But our films were read in real-time by radiologists sitting in the reading room in San Diego. So there was a shift of radiologists

[83] Covey, Dana, CAPT, MC, USN

in San Diego who were reading films at 0-dark-hundred because normally radiologists are all home asleep.

That was new and innovative. We were looking at limiting the number of people to bring too. We had about 300 people total, but again, whoever we brought had to have a real purpose, and if they needed to be replaced it wasn't going to be easy. So, in deciding what billets to have and all that, we had to be much more deliberate in our planning. And I decided it was much more important for me to have a civilian moral recreation officer than it was to have a radiologist.

The Navy was taking this over for the first time; it was a high-profile mission for the Navy, for Admiral Hagen and Admiral Ridenour. It was a high-profile mission for CONUS because we were publicized in a way that the European units hadn't been. It was a high-profile mission for the Navy line because it wasn't a geographic area that people associated with the Navy. There were operations going on that involved the Navy and the Marine Corps that were not publicized, and so we were given a level of support that was relatively unprecedented.

The United States did not have peacekeeping troops in theater contributing to the mission; all the peacekeeping contingencies were from other countries. Our main contribution was the medical mission. So it became important for the State Department to publicize what we were doing. We had all kinds of VIPs come during that six months. We were also the cover for some things. So, Secretary X who was coming to see the mission, but might also be involved in clandestine discussions with people or go to some place that was not publicized.

In addition to the Surgeon General and Deputy Surgeon General the Commandant of the Marine Corps, Secretary of the Navy, Secretary of Defense, and Chairman of the Joint Chiefs visited during that six months. It seemed like every other week we were showcasing some high-flying U.S. official what we were doing there. The Army and the Air Force units didn't have that kind of visibility. They did the mission and they did a good job, but it didn't have that kind of diplomatic visibility that we had. We were not only doing things from an innovative medical standpoint, we were doing things from an innovative strategic standpoint.

Did you send any of your staff downrange to assist with special missions?

The units downrange tended to be very small groups, number one. We made some trips downrange and I myself went downrange more than once. I sent my physical therapist downrange to deal with a unit that was in a very rough terrain and they were having a lot of combat injuries. And the problem was if somebody got hurt in this particular area, they had to send them back to Germany. I mean, there was no leap, and it was a huge issue in terms of keeping this particular unit operational when they were dealing in very rough terrain, or what do they did with even a fairly severe ankle sprain. If you have an ankle sprain you can't function. Well, if you can't function now you're down a man. You can't keep the guy there easily. He's got to be sent back to Germany, and so it's a big deal.

I found out about it and I sent my physical therapist down there, and he instructed the unit on some basic preventive things that they could do to not only mitigate those kinds of injuries, but prevent them. And as a result, that directly

contributed to the increased efficiency of that unit. Again, that unit was not operating in an area or under acknowledgement by U.S. authority, so I can't say a whole lot about where they were, how they sorted out or even what service they were from. I don't know how much of this may be classified and what's not.

Understood. What about high-profile patients? I understand that the hospital treated some Russian soldiers.

The level of care depended on where you were from. The quality of the care you got on the frontline depended on the quality of what was available for your particular country of origin. Once you got to us we were able to not only stabilize, but we were able to do definitive care. We were augmented with equipment capabilities beyond the standard fleet hospital at the time. Like I said, the only thing we didn't have was the CT machine and we arranged for one because the local Zagreb doctors were able to send people downtown for procedures; they would get the CTs and then we would transmit the CT back to San Diego for it to be read. So, Zagreb Hospital would do the CT; our doctors back in San Diego would interpret it.

So, if you were a First World country, no matter how bad your service member was hurt, you could come to the fleet hospital and we'd stabilize them, and then usually within four to seven days, a fixed-wing aircraft would land on the tarmac, a bunch of doctors and nurses would get off, there would be an orderly transition and then that person would be loaded onto that fixed-wing aircraft and be flown back to Ottawa, London, Paris, Stockholm, Oslo, Berlin-depending on your country of origin. The rest of your care would be done by that country's socialized medical system.

If you were Second World country like Poland or Russia-you had the capability because of distance of getting a CASEVAC, but it lacked the capability to do some of the definitive care that we could do even at our fleet hospital. The Third World countries like Pakistan and Jordan lacked the capability of getting that air casualty back home. We didn't take care of First World casualties longer than ten days, and usually they were out of our facility in a week or less. The Second and Third World casualties we took care of for as long as we needed to take care of them. We took people with severe extremity injuries all the way through prosthetic fits and rehabilitation.

We had a Russian who had lost his leg. If he were sent back to Russia with an amputation he was looking at a life of selling pencils on the street corner. It's interesting how you arrange for all that-negotiations and what not, but the U.N. paid for it. The funding for this definitive care had been worked out between the U.S. and the U.N.

We were providing medical care at a level two and a half; we did much more than usual battlefield medicine. We actually did a lot of definitive care, particularly for severely injured casualties from the Second and Third Worlds, which was new. I don't think the contingents before us had done that to the same degree, so we were innovative in that too.

And, they were good stories. Remember, the medical mission under our watch had become more visible through the United States for political, diplomatic, and other reasons than it was during the first 18 months. The news stories played well, particularly since we weren't fessing up to any of the other things that we were doing in country.

One of the people we took care of was a close friend of the Crown Prince of Jordan,[84] who was very grateful that we had saved his friend's life. So, at one point, he flew into Zagreb on his own private airplane, not like something you and I would fly on, more like Air Force One. At any rate, he entertained my command unit and the doctors and nurses who took direct care of his friend. He flew in and rented a villa of some sort and had what amounted to a state dinner for us, or like you would if you were back in Jordan. Trust me, it was extraordinarily lavish, and that was his way of thanking us. When that was over he flew his friend back home. He essentially came to pick up his a life-long friend, took the occasion and put on this "thank you" dinner for us.

Would you say that things ran rather smoothly with, if you will, those coalition partners?

For the most part. Like I said, the French required special handling; they always do. I'm not fluent in French, but I took four years of it in college and high school so I spoke it well enough and understood their culture well enough. With the Russians everything begins and ends with vodka. There is no business if you don't understand the culture. And with the French, no matter what you want there's always a lot of negotiation before you get down to whatever the business is and that's the way it is.

Were there any other particular days that stand out in your mind during this mission?

[84] Abdulluh II, King of Jordan since 1999. In 1994, as the Crown Prince, Abdulluh was serving as a Brigadier General with the Jordanian Special Forces.

I was looking at the cruise book and they had a big celebration for the 96th Commemoration of the Hospital Corps Birthday Ball in 1994. The Hospital Corps birthday is on the same day as my birthday, so I can always remember it. But there were things like that. I remember going into town for plays and whatnot occasionally. Again, whenever somebody like a VIP came there was usually some sort of social occasion attached to it, usually at some restaurant, so there were those occasions too. It wasn't infrequent for me to have to go into town to some sort of formal or semi-formal social function around a particular visitor. I got to know General Jones pretty well during that six months because he was there a lot.

There were things going on in country that were also being run out of Camp Pleso. There was a non-medical part of Camp Pleso. Operationally we were under the U.N. chain of command, as were all the conventions; administratively, I reported to a Marine major who was also on the compound. He was not only in charge of us, he was in charge of other stuff. I never knew what all the other stuff he was in charge of until I went into his command area there was other things going on at the time. Every time one of us went downrange, for example, I had to clear it with him.

Prior to deployment, was it a requirement to be familiar with the cultures and the languages of the region.

I don't know if it was a requirement, but I made it a point to learn and read as much as I could. I knew a lot about the different ethnic factions and what not. Like I said, when Ridenour called me I didn't know where Croatia was—I didn't even know how to spell Croatia—but I knew a hell of a lot about Croatia by the time I got there.

Was there a formal turnover with Fleet Hospital 5 in August of '94?

We had the same kind of change of command as my turnover with the Air Force. We had a formal change of command, which was interesting. I was going to say it was "diplomatic." The changeover between us and the Air Force was very collegial. I thought they did a great job with what they had to work with; I never spoke ill of them. It was very collegial. The Portsmouth people came with kind of a stick up their ass, and it was clear from the moment they got off the plane that they were here to do things much better than we had, and that they were here to show us how things should really operate; that was their attitude. Admiral McDaniel was there for the change of command, as my recollection. Remember, I said these two hospitals became proxies for those two admirals who were the running to be the next SG. So, let's say there was tension. I mean, as you went around it was like, "Oh, gotta fix this, gotta fix that."

Which is incredible, because all the press that I've come across about Fleet Hospital Six was very positive.

That's because it was. There was a clandestine negative campaign by the Portsmouth folks and Hagen had to intercede and basically tell them to knock that shit off. Remember, Hagen had been there personally. The Commandant had been there personally; the Secretary of the Navy had been there personally; Secretary of the Defense had been there. I mean, there were some high rolling people who had personally been there and had it not been with the highest praise for what we had done medically and the other things that we'd done.

With the mission over you were going to complete your tour as Deputy Commander of Balboa?

When Hagen came to Zagreb about halfway through our deployment, he said, "What are you going to do when this is over?"

I said, "Back to San Diego."

He said, "No, you're going to go to Bremerton to be the commanding officer."

We're approaching the 25th anniversary of Navy medical support in the Balkans, what do you think people serving today in the Navy and Navy Medicine should know about that time and what we did?

It was an extraordinarily interesting and deep mission for the United States. The United States, for the most part, does not engage in U.N. peacekeeping missions that often. Peacekeeping missions are a unique capability of the U.N., which for many member nations that is a major contribution of that country to the United Nations in a major way in which their military does military operations. If you look at countries who routinely have a large footprint historically in U.N. peacekeeping missions all over the world-think of Canada, United Kingdom, Sweden, Norway, Denmark, the Dutch, Germany-in terms of European countries, the French-depending on the mood they're in-it's what their military does, it's what their population expects them to do. It is not something that is part of the U.S. culture. The U.S. military does front-line contingent combat missions. Peacekeeping is not a major strategic imperative of the United States. If there's a peacekeeping mission the Canadians are always there, whether it's in Africa, Asia, South America, whatever, the Canadians are always part of it. The U.K. is almost

always part of it. The Germans are almost always part of it, and the Dutch-Norway and Scandinavia and Sweden-very much a high profile.

First of all, U.N. peacekeeping missions are operationally under the U.N., and administratively under the United States, which is true for all the countries-administratively. Countries don't give up their control of a contingent, but operationally they're under the U.N. That's not a comfort zone for a typical American mission, to be operationally under the control of the U.N. That's not a comfort zone.

The U.S. is more interested in the coalition mission, or NATO mission, not plainly the U.N. So, it was unique in that regard. And for us, it was unique in the attention and the PR that was paid to the mission at the time we were there, which was different from the previously 18 months or afterwards. We put that mission on the map with respect to awareness back in the United States. We also experienced some medical casualty management, particularly mine injuries, that were relatively unique because we were in a field hospital but we were taking injuries from normal combat field hospital care all the way through definitive care that you would get back in your country of origin. Like I said, the kind of things that we were doing for the Russians, the Poles and the Jordanians we never did for the Canadians and the Brits and French and Norwegians because their guys would all be back home in their country of origin within a week or so getting all the definitive care. So that was also somewhat unique for us because, typically, where we were, we weren't doing those kinds of things. We kept people for an extraordinarily long period of time compared to what was typical for a fleet hospital mission. So it was medically unique.

And again, we were the first CONUS unit to do the mission, so there were all kinds of innovations. And we were a composite; we were drawn from hospitals all up and down the West Coast. When we flew back we had a chartered DC-10 issued at Shannon Airport in Ireland. When we landed there everybody had to get off the airplane for refueling, so unfortunately we had to spend a couple hours in the terminal. It wasn't my option as to whether or not we were going to have liquor on the plane. The last thing I need after six months is to bring home a bunch of drunks. At the airport in Shannon the transient area had this huge bar, which of course you're in Ireland, of course, she's on draft. That was nice, and everybody got off and got a chance to stretch their legs and get a drink. We were still eight hours from home, so there was plenty of time for that to wear off by the time we got home.

When we landed everybody from southern California got off the plane, but then that same plane flew to Alameda and then it flew to McChord, so there were three drop-offs-Southern California, Northern California, and Washington. I did not go to sleep throughout the entire trip and I did not celebrate with my wife until I had word that the last of my people were home. And it was like 0-dark-hundred in the morning that I got the phone call from Whidbey that we're home.

And what do you remember about the homecoming?

It was pretty amazing. It was the way a homecoming should be. There was a huge contingent of folks there when the plane landed. It was that way when we landed in Alameda and it was that way when we landed at McChord. It was the way homecoming was when I returned on ship during Vietnam, the difference being the

positive homecoming continued in the community, unlike Vietnam where the positive homecoming was limited to the military base. But yeah, it's something to remember.

SESSION 5: 30 January 2019

Command of Naval Hospital Bremerton, WA

Admiral, when we last spoke, we ended the session with the homecoming from Croatia, and so we never got a chance to talk about how your command at Bremerton came about, and certainly what happened subsequent to that. I don't know how much you want to cover today, but certainly at the very least I would love to capture your time at Bremerton today.

Sure. Bremerton came about because Admiral Don Hagen came over—I believe it was around June timeframe—to pay a visit to us in Zagreb. He was very pleased with how we had been handling the mission, and so he made a trip over and he was very happy with how we were conducting the mission. He told me, "When you're done with this, you're going to go to Bremerton as the CO." So that's how I first knew that Bremerton was a possibility.

While I was gone, Admiral Nelson appointed Tom Burkhardt as the interim, acting deputy commander of NMC San Diego, so when I came back there was someone in my old office. In other words, the position had been filled by an acting. Hagen decided that I'd been at San Diego long enough, which was true. In total I'd been there three years. And since Nelson had an interim it was really no loss on his part. And as I recall, Dick Mayo[85] was the CO at Bremerton, and he got short-toured, I can't

[85] CAPT (later Rear Adm.) Richard Mayo served as Commanding Officer, Naval Hospital Bremerton, WA from October 1992 to July 1994. He was the Deputy Assistant Chief for Health Care Operations at the Bureau of Medicine and Surgery in Washington, DC followed by the Assistant Chief for Health Care Operations.

remember the reason why, it may have something to do with his needing to be at a joint job back at Washington.

I think he came back to TMA.

Yeah, he came back to TMA. And what they did was they slated up the XO, Nurse Corps officer, to be the interim CO at Bremerton. Because I was in Croatia, and I think Dick Mayo left in the spring-he might have left not too long after we deployed-and Hagen had determined that I was going to go to Bremerton. So, there was going to be a period of several months in which the CO of Bremerton was going to be vacant. And so, they took the XO and made her the interim CO, not just acting CO-she was designated the interim CO, so she was a full-up CO.[86]

When I got back there was really no pressure on the timing because Bremerton had a CO in the interim. Nelson had someone sitting in my deputy commander's seat. When I came back, I remained as the Fleet Hospital Six CO, wrote my after-action reports, took my leave, filed all that, and then went to Bremerton. When I got back, I had a separate office, and if memory serves it might even have been in a separate building.

Personnel issues at Naval Hospital Bremerton and Camp Pendleton

What was the state of affairs at Bremerton? Why do you think Hagen wanted you up in Bremerton?

[86] CAPT Barbara Mencik, MC, USN, served as the interim CO, Naval Hospital Bremerton from July to October 1994.

There were some issues going on at Bremerton when I got there. They just didn't happen because I arrived, they were ongoing. One of the things I found out was that there were some contentious personnel issues amongst civilians that had been festering not only at the main hospital but at several of the branch clinics-over at the shipyard, up at Bangor's sub base-a variety of places. And at the time, Bremerton had a fairly confrontational union with a particularly confrontational union leader, and these personnel issues were such that I wound up about a half a dozen work centers that were really dysfunctional-people were talking to each other and everyone was charging discrimination and harassment, and it was a mess. So that's what I inherited. And I'm not blaming Dick-upon further review this wasn't a function; I don't think of poor leadership on his part. It was a function of the personalities involved who were causing the problem.

When I was at Pendleton, Don Hagen was one of my commanding officers, and while he was a CO Don Hagen appointed me as chairman of the Department of General Surgery, and subsequently also became DSS, even though at the time of the appointment I was a commander, so I was fairly junior.

In 1986, I blew out a disk in my neck and had a C5-6 fusion down at Balboa, which caused me to be TAD'd to Balboa for about six months for recovery. At that time, [Robert] Higgins had just taken over as CO and the General Surgery Department had a secretary who'd been there forever named Dorothy Stafford. Dorothy was kind of like

Donna.[87] She'd been there forever and she'd been through lots of chairmen and had a corporate memory in history that was invaluable. So, if you were in any kind of leadership position in the Department of General Surgery, or any other Surgery Department period, if you didn't pay attention to what advice Dorothy was giving you were undoubtedly going to make a bad decision about something.

But Dorothy was nearing retirement age, and I believe her position was a GS-5 or GS-6-she'd been there for a long time-she'd had all the QSIs and what not, so she was maxed out in terms of how high she could rise in that position. I believe the retirement formula for that time depended on what you held the last three years that you were in civil service. So, from a retirement standpoint, it was important for her to get a higher-level job. Also, for the amount of time that she spent and the work she deserved it. I encouraged her and supported her moving to a GS-8 position that had opened up, which had the potential over three to five years to rise to GS-10 or something like that. She applied to that job, and when she ultimately retired, she had a much better retirement situation because she deservedly moved to a higher promotion job, which left her former job open to fill. And so, I had a search and I interviewed half a dozen people, and decided on a person who was a secretary in quality assurance in the command. She was a GS-3 with an excellent recommendation from her department head who was a Nurse Corps officer in the QA Division. So, it was not a patient care office or division, it was a much smaller division than general surgery was, so that's why it was a GS-3. I

[87] Donna MacKenzie, long-serving (five decades) civilian secretary for COs at the Naval Medical Center San Diego, CA.

think all total there were maybe half a dozen people in the department; whereas, in surgery we had eight surgeons alone, not to mention all the corpsmen.

So, I selected her because I thought A: she was the best qualified; B: I thought it was good for the system to see progression, so she was a GS-3 who now gets a GS-5. Dorothy was a GS-5 who moved into a GS-8, and I thought that was all healthy from the standpoint of civilians seeing that it was possible to have upward mobility within the command; therefore, you had a better chance of keeping good people. So, it's all positive. She also happened to be African-American; therefore, she was a minority and her husband was the sergeant major of one of the generals on the base. Again, we were getting someone who was a spouse of a valued senior enlisted person, so in my mind this was a great selection for many reasons-first and foremost, the person deserved it, but then when you checked off all these other, sort of, tangential collateral boxes, it was a feel-good story for the system.

And so that happened, and she became the secretary and shortly after that, maybe a few weeks or less after she became the secretary. I got my injury and wound up going to San Diego for six months. And while I was down there things fell apart in the Department. She got into it with a couple of surgeons and she filed a discrimination complaint against one of the surgeons on the basis of race and sexism, and since I was still the head of the department I got named too, which was interesting that I could get TAD'd to another command and I could be named as discriminating against her sexually and racially. A: I wasn't there; B: I'm the least likely person to do that. So, it was interesting. Bottom line is even though I was down at San Diego essentially

convalescing for six months, I was detailed one day a week to straighten this out. I had to go up to Camp Pendleton to figure out what was going on. Long story short, it turned out that it was a mismatch, completely unforeseen. It took me quite a bit of time to unravel all the particulars.

Surgeons in general tend to be action-oriented individuals and tend to be more extroverted than introverted. Our people skills can sometimes be lacking-the choice between people skills and making life and death decisions-we make life and death decisions and sometimes people skills suffer. It's a common stereotype for surgical personalities, and not undeserved. Dr. Longmire was very different from that stereotype. He was very much not extraverted, never shouted, that sort of thing, but the stereotype I described to you is certainly not uncommon in the surgical community, and if you were a captain in the mid-80s, then you were trained, just like I was in the late 60s, early 70s, in that kind of environment, so that's who you were.

So, this one particular captain was what I'll call a typical surgeon. He was short and stocky, kind of Napoleonic-not great on people skills, but a good surgeon and he fit right in. And I'll paint the situation. Dorothy had been there for decades, knew all the ins and outs of all the different personalities, knew exactly how to deal with whoever, so there was never any conflict because she was a master at dealing with whoever you were. It turns out the person I hired-although on paper looked to be absolutely the right choice-all the right recommendations, great interview, etc.-but on further review was the wrong choice because where she came from. As I said, she was from a QA department, which had maybe half a dozen people, all of whom were female-no patient care area, so

there weren't corpsmen, it was a support function area, and she did great. In the General Surgery Department, you have diverse personalities, diverse genders, and patients—who are sick—aren't necessarily on their best behavior. And so she was put into an environment that she had never really been in before. That's number one.

Number two: on further review and this isn't something you'd get in a performance appraisal and you can't even really talk about it, but when I said to the Nurse Corps officer, "Tell me little bit more about her."

"Well, she's a great worker, but sometimes she has days when she's a little off her game." Wink, wink. Okay, so I'm a doctor and pretty experienced, and I know that means she has raging PMS-it's a real phenomenon. For some women PMS is a real significant thing. And it's not a sexist thing, it's a real physiologic happening. But in a department that's all female with not very many people, no patient contact, when she was having one of those couple of days a month every month, they all understood it, because who knows? Maybe some of them had it to some degree. So, she was in a very supportive environment when she was having one of those days. She didn't have to miss work; she could just kind of go off and do work on her own and people knew not to mess with her, and they understood it. They didn't see it as a weakness or anything. I put her in a surgical department that's lots of patients, surgical patients, male dominated, and when that day came up it was a recipe made for disaster. So, on one of those days in walks Captain Napoleon, if you will, who wants to know where the on-call roster is for the next month. And so, he's got a few minutes between two cases he's doing, and he wants to know what the on/off schedule is going to be for the next month.

She was having one of those days and said, “You can’t talk to me that way. You have to ask me nicely.” So, he walked in with a smoldering fuse, because he was between two tough cases; he didn’t have much time, and she lit the fuse. And so, you can imagine there was a verbal confrontation. She said it was physical also-he never laid his hands on her, but he got into what she considered her personal space. Now, on one of her days, her personal space is an office wide, basically, you know what I’m saying? It’s her personal space that includes seriously her entire office. If you walk in there, you’re in her personal space. On a normal day you’d have to get in her face. He wasn’t really in her face; he was just in her office. And, of course, she went high right, it got worse, she stormed out and told her husband who is a Sergeant Major for one of the commanding generals. This escalated to DEFCON-1 in like two hours. So, I sorted all that out over the course of several weeks, and the resolution was I got her transferred to another GS-5 job where she was working in the safety office, which was all civilians, so no military people. There were like two or three people in the office, and the safety people probably spent at least 50 percent of their time outside the office because they were out doing inspections and surveys and whatnot, so it was an ideal fit for her because she’s very capable. Again, she’s not working with not a lot of people, no direct patient contact, and much of the time she was on her own because the people she was working for were out in the field. And then I got a different secretary, so that’s how that got resolved. So, I don’t know how much Hagen knew about that. He must have known something because this thing blew up, I mean really blew up. I mean this was getting ready to hit the papers kind of thing, and I got it all under control, didn’t’ get any bad press over it.

The CG was happy. She was happy; everybody was happy. It literally took me three weeks of activity off of my convalescent bed to straighten this out. So, I don't know if that had anything to do with my going to Bremerton. I think not, but as it turned out that experience served me well. Because as I looked at all these different personalities at Bremerton, I quickly found a common ground.

I went through all these work centers and figured out who the players were and what's going on. The common denominator for all six of them was the union leader was intimately involved, and not in a good way. So, he was in the midst of all the goings on and was always taking a position, which didn't lead to a good outcome. And aside from the dysfunction in the work center-I mean, there were job accidents and whatnot, this stood to cost the command a significant amount of money if all this went south, okay? This is aside from the bad PR. It took me most of my three years to settle all six of these cases, but by the time I left the command, I had resolved all six of them. Five of the six were resolved with no personnel or economic hits on the part of the command. One, I resolved because I thought she had been discriminated against by her supervisor because they didn't get along. She was a nut case and-I don't know how you make this stuff up-she was a credentialed employee who got into an affair with a psych patient, who was discharged and it continued on the outside, a sordid affair. I can't make this up, she was involved in some kind of swingers' thing gone bad or whatever, it was awful. Bremerton's a very small community and it's hard to keep this kind of stuff discreet. It apparently got back to the command and her supervisor took a very negative view of her based on her activities.

Now, understandably, because first of all, the person that she was having this affair with was a patient at one time in psych, from an ethical standpoint, it's pretty bad. And aside how you feel about swingers and that whole thing, people think that it's immoral, etc., so her supervisor sees her as immoral. What she did in her private time was her time-valid argument, but there was a conflict; that's how the conflict started between supervisor and employee. It grew because the employee wanted to go to some sort of training seminar in Seattle, which was a bit of a perk and she was denied that. So, she brought a complaint saying she was discriminated against, on and on and on. I resolved it, and I did feel that the supervisor, while morally outraged, went too far in bringing her personal views into her oversight of this particular employee. As much as anybody, I might not favor what she did in her private time, but what she did on her private time could not be the basis of evaluating her performance on the job. It certainly couldn't be a factor in determining whether or not she was eligible or deserving of training and education, which could make her a better professional. So, I granted her that, which cost the command about $1,500, and resolved the situation.

The other side I resolved by the command taking no hits whatsoever, and because the union chief was also a worker, I started taking a careful look at what he was doing. It turned out that he was spending virtually all of his time doing union stuff, spending virtually no time working in the shop doing his regular wage grade job, and was a bit of a bully, and wasn't really liked that much by the other workers in his area. So, I figured out a way to create situations where his lack of working was called into question by his fellow workers who didn't like the fact that he was getting paid to be a

supervisor and wasn't doing anything. He was doing his union job and wasn't doing his civil service job, but was still getting paid for it. They didn't like that. So, the next election, he got voted out. And labor relations improved dramatically. There's more than one way to skin a cat.

One thing I failed to ask you, Admiral, is were you still practicing medicine at this point in your career?

At Bremerton, yes. Bremerton, was a family practice hospital, and I instituted something that we had done at Pendleton. At Pendleton we had a general surgery resident from Balboa rotate up on a three-month rotation. Depending on where you go to finish general surgery, depending on what kind of assignment you get, particularly, on ships and in some more remote areas-and remember, this is now the mid-90s, and the gender-neutral organization of the military is now in full swing. And general surgeons can be put into billets where they may have to do a fair amount of gynecologic-type work, if you will, because in that particular area, not the least of which is how do you do a C-section? So, we had them rotate up and the main reason for them being there was someone had to do C-sections because remember, this is a family practice hospital. Family practice residents are not going to do C-sections. They do a lot of births, but not C-sections. They're not taught how to do C-sections. That's a gynecological surgical procedure. So, if there was a C-section, it made sense for the surgery resident to scrub in on that to learn how to do C-sections. It was an excellent situation because family practice guys end up taking care of the patients, the whole thing-the OB and all that. So, for the surgery resident, the only thing he had to do was go in and scrub on the C-

section, he didn't have to deal with the OB service, he was on our service. But also, he was an extra pair of hands, and for the surgery resident it was a good deal because when we were operating, we let him do all kinds of stuff. So, it was an interesting situation.

So, when I got to Bremerton I talked to the commanding general down at Madigan, and we were talking shortly after I got there, and long story short, decided that that kind of thing would be useful for the general surgery program at Madigan. So, in essence, we instituted the same thing where on a quarterly basis there would be a surgical resident who would rotate up to do sections on the OB service, and the rest of the time he would be helping us in general surgery.

Because I had that resident, I was able to have my own kind of clinic in which I would have my own cases. It allowed me to do things different than just family practice residents. I could do more complex cases ethically and could follow-up and whatnot, so yes, at Bremerton I still maintained my surgical skills. Not as much as if I was a regular staff surgeon.

Advent of TRICARE in Military Medicine

I would think one of the great challenges of being the CO at Bremerton from '94 to '97 was the implementation of TRICARE and everything that entailed. What do you recall about that time?

I was a crash test dummy in every place I'd been going back to the TRICARE Demonstration Project. TRICARE was getting underway when I got to Bremerton, and

we had 12 regions, of which, as I recall, Bremerton Northwest was, I think, Region 11 if memory serves me. Region 12 was Hawaii; Region 11 was the Pacific Northwest-Nine and 10 were California. Nine was Southern California; 10 was Northern California. So, Region 11 was Pacific Northwest and Alaska, so it included Oregon, which had no active duty bases, all the bases in Washington State, Idaho-I don't think it included Montana. I think it was Idaho, Oregon, Washington, and Alaska. So, a lot of territory. But only two of the four states had a lot of capability; there was no really direct capability to Oregon-there are no active duty bases in Oregon. Idaho only had Mountain Home, the Air Force base. But it was also determined that Region 11 was the first region that was activated. So, when TRICARE started we were the first region that started. And, of course, obviously Madigan, being the biggest treatment facility in the region was the center point. But we developed all the growing pains with TRICARE developing network, etc.

In addition, Washington State and Northern Oregon was a very forward leaning area with respect to civilian healthcare at the University of Washington, University of Oregon, which were highly rated academic centers. You had the city of Seattle, which was a very forward leaning civilian community in which they didn't have Kaiser, but they had a Kaiser-like organization. But in terms of different ways of delivering healthcare, the Puget Sound Region civilian sector was pretty much ahead of the curve, and it was a good relationship between Madigan, the University of Washington, the University of Oregon and Portland. They all worked together on a lot of regional things-trauma care, cancer, etc. And in fact, while I was there, we created an organization called the "Puget

Sound Healthcare Network," which was Bremerton, Madigan, the University of Washington, University of Oregon Health Center. It included the major civilian health networks in the area. And we met on a quarterly basis to discuss and implement regional things that we could do cooperatively, which was in everybody's interest. It was particularly in the interest from the TRICARE standpoint in terms of developing civilian networks and cooperation, particularly in areas where there was not a lot of direct care capability. So, it was very exciting in that regard. We did a lot of innovative things with respect to systems healthcare delivery.

Inspection of Bremerton's Subordinate Commands

Remember, I started the Navy from the operational side, so I was able to visit and understand the operational issues that were going on in that region-visiting our nuclear reactor capability in the middle of Idaho because they had a clinic there; going to Adak because they had a clinic there, a base that mainly supported submarine care; understanding what the other services were doing, understanding what the Air Force's challenges were up in Anchorage, the Army's challenges in Fairbanks, Alaska. I've been to Alaska many times, and not just in the summertime when it's warm and the sun goes down at midnight and comes back up at three or four o'clock in the morning. I've been there in January when it's just the opposite where the sun comes up closer to eleven o'clock in the morning and goes away at three or four in the afternoon. I've been in Alaska when it's been 90 degrees and I've been there when it's minus 60 degrees. To

Alaska people—particularly the part of Alaska that's not the southeast part where the capital Juneau is—there's a bunch of fuel rigs and it's more temperate, more weather like the Puget Sound area-a lot of rainy weather. You get away from that southeast part of Alaska and get into what I call the real Alaska, the frontier part of Alaska. Alaskans don't consider people as really visiting them if they don't come in the winter time.

It's a whole different experience.

You're kind of a fair-weather fan. You've been to Alaska in summer you're not real serious. You show up in January you're serious and the people respect you more.

You're on this inspection tour and you go to these places. How long would you typically stay in Adak or Idaho or wherever?

If you go into Adak it's really an automatic two-day visit. By itself it's several hours. And it's an interesting flight because depending on the weather you reach a point of no return. If you get about a third of the way there and the weather's bad, it's socked in, you turn around and go back to Anchorage. Sometimes, depending on the weather situation, particularly in the winter time, a one-day visit can turn into a several days visit. You also sometimes reach a point of no return, meaning you get past the halfway point, the three-quarters point and the weather turns really bad, you find a way to land there because you don't have enough fuel to get back to Anchorage, which happened on one of my trips there, the pilot said, "Well, it's really nasty, but we're past the point of no

return so we're going to have to land." That was the flight where I literally had my rosary beads because I thought we were going to crash.

I can imagine. That sounds terrible. Did you encounter any notable issues with these constituent clinics?

Generally speaking, the Navy and the Marine Corps does a pretty good job of screening and vetting people-not always, in any situation you can find malcontents. And a malcontent that's going to a remote place can really be an ugly situation. Adak originally was built to accommodate dependents; that's why it had a high school and everything else, so the base itself in its original form was pretty active, even though its mission was fairly limited. But in order to have a base to do the kinds of things they did there in a remote and isolated environment it needed to have a pretty large logistic support footprint. You needed to have an airfield that could be maintained in bad weather, so that requires a cadre of aviation type people to essentially run an airport in bad weather conditions. Those people have to be fed, etc., etc. And aside from the submarine mission, Adak was the northernmost spot for P-3s. While I think the P-3s might have been homeported in Hawaii, they would certainly come up north on patrols in that area-obviously Russia's there and there's a lot of worthwhile things for them to be surveilling, and so it was a base that also accommodated P-3 landings who would come in for refueling and that sort of stuff. But because they were so remote it was a base that had to have a supply of spare parts because if a plane broke down-you can't fix it, but you can't get rid of it either. So, the submarine communication mission and the transient northern Pacific aviation mission required a substantial cadre of people. And

when you get into numbers like that, if you're going to have that kind of base for the mission, you got to have people who want to bring their families. A high percentage of the people who have the skills to provide the services that are required are also married and have kids. So, as I said, it was a pretty substantial base with a large, significant dependent population large enough for an elementary school and a high school. And because it was isolated, you had to provide all the services. So, the high school had a huge swimming pool-it was essentially an Olympic-sized pool, because guess what? You can't have an outdoor pool in that environment. And if you're talking about the kind of activities you have to have, you have to have the capability for a lot of indoor activities. The base was connected by subterranean tunnels, so when it got really bad you could get to most places on the base through tunnels and not have to go outside all the time. It required a lot of people to support the missions, and it required a significant clinic, because again, evacuating somebody with a medical issue is hard to do.

I can imagine mental health was a significant issue in an environment like that. Were there more mental health providers out there than at other clinics?

There was a psychologist. I can't recall whether or not there was a psychiatrist. There may have been one on a rotational TAD basis; there was not one permanently assigned. It might be that once a month a psychiatrist came up and it was a resident-clinical psychologist permanently assigned.

But actually, there were a lot of people who liked Adak. You say, what kind of crazy person would want to go there? Well, if you had a young family with kids under the age of 10 (most kids under the age of 10 still think their mother and father are the

best people on Earth) it was a great place to be. If you're an outdoors person who likes to hunt and fish and nature and all that, it's a great place to be. The dominant predator on the island is a bald eagle, who are much larger than the ones you find in the lower 48. And they're the dominant predator. The largest mammal indigenous were otters. There was lots of fishing. So, if you were the sort of person who likes to take five-, six-year old kids out and do mom and dad kind of stuff, Adak was great. If you're a ten-year old and you got a swimming pool like this, you're fine. And no distractions from the real world to compete with, so it was kind of a cloistered family place and a lot of people liked it and liked the experience. It was not everybody's cup of tea. But as the mission diminished and where the problems really started-mentally and otherwise-was in the Navy reducing its footprint. They decided to phase out the submarine mission, and so Adak was going to go away. And so it reached a critical mass point where the number of people doing the mission, basic missions, was reduced and the P-3 sorties were going down and then they shifted the P-3s to Japan for refueling, so the company tours went away and Adak became, a one year, geographic bachelor tour, unaccompanied. That's when they started having a lot of problems-mental health issues, disciplinary problems-because now you have a very different environment. You have an austere environment, and what amounts to an endless ship deployment. So you're there for a year, and I suppose it's kind of like when we went to Croatia, that was probably a period where you could take a week's leave and go to Anchorage or someplace like that, but by and large, you were there in this remote place without family, which obviously a lot of the people that got sent up there now were still married and still had kids, but now their

kids are back in wherever, and now they're up here in Adak. So, the two years before the place closed, which was during the timeframe I was there, it was not a pretty sight up there in many respects.

Where I stayed, I had the house to myself because there were no families there anymore, so I would be billeted in a house that used to have toys for the people in it- mom and dad and a couple of kids had the whole place. Go over to the swimming pool and I'd be swimming in this big pool with one or two other people. So, you could see all the things that were there to support an accompanied tour. When it's unaccompanied, what do you do? You're done with your work day and what are you going to do? There's only so much you can make up that seems like it's worthwhile. It gets old quickly.

I was dealing with stuff that previously, like I said, wasn't a big issue. When the base had accompanied tours, life for many people, especially with young families, was considered pretty good. Think about some of the colonial experiences between the 19th and 20th centuries, when Britain had 450 million subjects and the "sun never set" on the British Empire. You had all these expat Brits living all over the world in some pretty crappy countries, but this was just great because they were inside this bubble. So, an accompanied tour with a young family in Adak isn't so bad. A lot of our folks in the military come from places like that. If you're a sailor whose home was northern Idaho, going to Adak wasn't so bad; it's kind of what you grew up with. We got a lot of people in our military organization for whom that kind of an environment is reminiscent of what they had as children. They don't think it's so bad. They don't think it's so bad to be isolated. And remember, they're given everything, it's not like there's no TV, there's no

school, there's no activities. We put all that stuff there because it was so isolated. So, in terms of facilities, back in the accompanied days, they had better facilities than a lot of bases we'd been to where the base depends on the surrounding civilian community to make up for some of those deficits. Well, there is no surrounding community. The high school had great teachers because the teachers were brought there to teach those kids [and] got all kinds of extra money for doing this.

There were smaller classrooms, a patient population that's motivated, no issues with parent/teacher association, no issues with parents not being involved in their kids' education and not being supportive, yada, yada, yada. It was kind of idyllic for a while.

So, in the end it's really not a bad deal getting orders out to a place like Adak.

I'm not so sure I'd say the same about Idaho Falls.

Well, you got to draw the line somewhere (*laughter*).

If you were assigned to Idaho Falls you didn't live on that base. People went to that base for shifts. There really wasn't a living on base, per se, where the reactors where. So, you would live in Idaho Falls, or Idaho Falls area, was not exactly a raging metropolis, but that's where your family was. I don't know what the school system was like, but I'd be willing to bet it was not necessarily the top of the pack. So, there you are living in Idaho Falls and service members commute 40 miles a day because it's an isolated place and he probably works 24-, 36-hour shifts, or however they had it laid up, and then he goes back home.

Nukes have kind of their own personality anyway, so it probably worked for them. You want someone who's uptight, detail-oriented, goes by the book. That's the only kind of person you want to deal with nuclear weapons and nuclear propulsion.

On Becoming a Flag Officer

So, at this point in your career, did you have any expectations for what the future would hold or where you would serve next?

I developed an attitude early on that the needs of the Navy always come first, without exception. And so whatever dreams you had, whatever you thought was the right place and the right direction for you to go there's always somebody superior to you that's got another plan. And your idea and your plan, whatever the guy above you has in mind, that's fine, if he doesn't then you still have to make the best of the situation. If you can't accept what you're being ordered to do, then you have to leave at your earliest opportunity. It's not a complicated system. If you can't follow the orders, then at your first opportunity you have to leave. It's pretty straight forward. That's what you sign up for. And nowadays, that's what you always sign up for. It's a volunteer organization. In this day and age, nobody can say, "Well, I wasn't sure what I was getting into." Of course, you knew what you were getting into. I mean, you've been watching it on CNN, Fox News, ABC your entire life, pulling it up on your little iPad, iPhone, whatever device you've kept your nose buried in all the time. It's right there. It's not a mystery. Well, you got a contract that says you're in for three years; then after three months you've made it, you know what? You still got another 33 months to go and then you can get out.

That's the contract. And that's an invaluable lesson for a lot of people who seem to think that contracts aren't really contracts. You may alter how you execute your contract, but you still have a contract.

At that point, as you're closing out your tour of Bremerton, did you have the feeling that you were going to be a flag officer?

You know, there are certainly people in the organization from the day they are born that determine that's a goal for them in life. And certainly, as I moved along, the kind of people I encountered there were people who thought I had that potential. But for me, it wasn't about doing things so I could become a flag officer because no matter how great your career was, if you're betting on becoming a flag officer, that's not a good bet. You're over/under is very marginal and that's not really good.

The year that I was selected for flag I was the only Medical Corps flag select that year. And in a robust year, there's usually not more than two, but often only one; sometimes none. Having sat on numerous flag selection boards, when the board starts, they bring in all of the eligible O-6s, and in a medical community you can start out with plus 100 records, maybe 200 records. You eventually get down to a short list of six to ten really serious candidates, of which you reduce it to one. But when the process starts, your chances of making it are, in any given year, less than one percent no matter how good your record is. So, I don't think it's a good bet to base your career on trying to become a Medical Department flag officer.

When you get down to the short list, you've got six to ten people based on their record, all of whom deserve to be selected. So, deserving to be selected and having a

great record, that's not the ultimate determiner. That's what just gets you in the finals. The ultimate determinate is, is this selection the best thing for the Navy at this time? Those are the tie-breakers. So, no matter how good you are; no matter who you are, if your set of experiences and whatnot that you bring to the finals isn't the best selection for the Navy that particular year, then you don't get selected.

So, my attitude is you should always strive to perform well in all circumstances and opportunities and eliminate or avoid things in your record performance that would de-select you. So, if you're a complete idiot or an asshole, you're probably not going to make the short list ever.

If you have a career that is wonderful but also narrow, you probably are not going to get selected. If you had a career in which you're the best that has ever or can be but you spent it all in one place, you're probably not going to get selected. To be a world-renowned clinician is one thing, but if you do one thing and one thing only, but you do it extremely well, you're probably not going to be selected as a flag officer. So, you have to be really good; you have to have a diversity of experience and opportunities, all other things being equal. If you look at the line in particular, they have certain requirements. If you haven't done certain things you'll never get on the short list. If you've never had any professional military education; you've never been to War College or that sort of thing, you're not going to be on the list. That's the way the Army and the Air Force, and to a lesser extent, the Navy and Marine Corps do it; but the Army is totally hard core on that. If you don't punch that ticket when you're a major or a young lieutenant colonel, you're done. You're never going to be on the flag list. You're probably never going to get

to be on O-6 either. So, they provide certain pathways of experience and they get put in that position and you have to perform in that position. You get put in a position that is one of those positions that everybody who's on the short list for general has, you get put in one of those theater positions and you do poorly you're done. If you have no operational experience you're done. If you've only served in one place you're done. If you are in a community that in and of itself is so narrow there are minimal opportunities for you to do anything other than be at either Bethesda or San Diego, because those are the only two places that have this kind of nuclear medical care, isotope care, only two places, so if that's what you're going to do you're going to be either at Bethesda or San Diego. If you are a harrier pilot in the Marine Corps and your activity is flying harriers you're going to be at Cherry Point or you're going to be at Yuma, period. Those are the two bases that had harriers. But, when you're someplace else, when you're on non-flying tours then there are other things you have to do. So, the military sets up a hierarchy of jobs where some jobs prepare you more than others for higher responsibility, and they put up and coming people in those jobs and see how they do, and the ones that do very well get other jobs. So, you know, as my family taught me, it's all about opportunity. Whether or not you become a flag officer really depends on the opportunities that you are given along the way. You're not in charge of that. Somebody else is. What you're in charge of is if you get that opportunity you need to perform well. For me, it's always about performance in whatever opportunity you're given. I was fortunate that I was given opportunities that put me on the flag path. But it wasn't me who went out and campaigned.

I hear some flag officers say that in their careers they were "groomed" for that job. Does that ring true?

I think that's not an uncommon view by folks on the outside, also by folks on the inside. The people who are in the flag and general officer positions have an obligation. There's one thing you can say about a general officer position and now you've been selected. From the moment you've been selected you can pretty much start the countdown to when you're leaving. In fact, when you're selected, from the day you put on the star you're on a three-year clock, which means it's an up or out situation. It's not like O-6 and below where you can lateral move here and there depending on the community. The flag community-because Congress sets the fixed number of positions-it's up or out. If you're not selected for the next rank above, you're expected to put in your papers. And you actually sign that. Part of your orientation as a flag officer is you sign an agreement upon selection as O-7 that I'm going to serve for three years and if not promoted or detailed to some other positon, at that point I'll put in my retirement papers. That's the agreement.

So, in my orientation at O-7, by CNO congratulations, blah, blah, blah, welcome to flag, yada, yada, yada, 50 percent of you won't be going on. So basically, 50 percent of you need to start preparing your retirement portfolio. Nobody says that when they make O-5, O-6, it's always this idea that it's possible. And then when you get there no one says you got to leave in three years. But that's the way the community is set up. So there's a natural turnover that's part of the flag and general officer's community, which means those who will be in the flag and general officer community have an obligation to

be sure that the pool that's going to replace them always remains large and robust, which means you have to identify people that have characteristics that might make them good flag general officers someday. And if you find that, then you work to recommend and work to give them positions of responsibility going forward, which allows them to demonstrate that they do have that potential.

Back in the 90s, the Marine Corps actually had more African-American general officers than the Navy had flag officers who were African-American, even though the Navy is a much larger organization numbers wise than the Marine Corps. But during my tenure, some of the potential flag selectees got knocked off the track by various and sundry issues-they got selected, somebody was able to bring a suit or an allegation that they had been harassed, or some sort of thing. So, the Navy went through a period where they did select some African-American flag officers, but some were knocked off the track. I remember one SEAL who was selected-he got knocked off the track because of an accusation. I don't know if it was ever proven, but he got knocked off the track. Well, when you get knocked off the track as a SEAL, you know, it may be many years before somebody else comes along who's African-American who satisfies all the requirements, etc. So, there was a point around the turn of the century where the Marine Corps had more brigadier generals who were African-American than the Navy had admirals. And somebody asked General Mattis, "How is that possible? What is the Marine Corps doing that they're able to do this?" And Mattis said, "Well, it has nothing to do with what the Marine Corp's doing today; it has more to do with what the Marine Corps did 15 or 20 years ago because requirements in the pipeline of becoming a

general officer hasn't changed. What has changed is the number of African-Americans who had the opportunities and experience and the performance that makes them competitive. So, the visionaries for doing that are not the people who are doing the selection now. The visionaries who are doing it are the people who were there 15 or 20 years ago. That's what Mattis said back in the day.

Now, according to my records, you are the first active duty African-American flag officer selected in the history of Navy Medicine. Am I incorrect?

Yes, I am.

I know back in the early 80s Dr. Bernie Johnson[88] was rumored to be a future flag.

Yeah, there were two. He was one; I forget the name of the other. Gene Fussell[89] was an orthopedic surgeon and a full-time reservist who was selected a few years before me. Gene Fussell lives in the Oxnard area. When I was selected, there had not been an active duty African-American Medical Department flag select. And by the way, the board two years before me selected Al Diaz[90] and Bonnie Potter.[91]

So that was '97 right?

Correct, so when they were selected, Al was the first Hispanic-physician, and Bonnie Potter was the first female, non-Nurse Corps selectee. And then the next board

[88] CAPT Bernett "Bernie" Johnson, MC, USN (1933-2006) served as Commanding Officer of Naval Hospital Yokosuka from 1977 to 1980. He is the first African-American physician to hold the position of Navy hospital CO. He retired in 1980 following a 22-year career in the service.

[89] In 1993, RDML Maceo Eugene Fussell, MC, USNR was selected for flag rank becoming the first African-American medical officer to attain this distinction.

[90] RADM Alberto Diaz, MC, USN, was the first Hispanic physician selected for flag rank in the Navy.

[91] RADM Bonnie Potter, MC, USN, was the first woman physician to attain flag rank in the Navy. She is also the first female physician to attain two-star rank.

selected a female and then I was selected. So those three medical corps boards, for three years running, the selections were not Caucasian males.

I left Bremerton in ’97 and I went to Health Affairs. I was selected the year I was in Health Affairs. So, it would have been the FY99 board. After I was selected, I moved into the TMO job in August of 1998 as a rear admiral select.

The Medical Officer of the Marine Corps (TMO)

So, Admiral, how did your position as TMO come about?

Hal Koenig was the outgoing Surgeon General and he had me penciled in for San Diego, but Dick Nelson was the incoming Surgeon General when I was selected, so he had the final recommendation to CNO. And remember, when I went to Croatia, he fleeted up Burkhardt as the acting. And let’s just say that while I was in Croatia, my need to go back to that job disappeared, for whatever reason. I left for Croatia working for Nelson, but I don’t think he was unhappy that I wasn’t coming back, let’s put it that way. I don’t think he was particularly happy that I was going to his old command at Bremerton either, but he had no say about that. So, I went to Bremerton and the rest is history.

Now, forward to my getting selected four years later when Nelson is the incoming SG. When I was selected Admiral Koenig said, “Congratulations.” And Admiral Koenig had me penciled in to go back to San Diego as the Commander. Admiral Koenig liked the idea of “fresh caught flag officers” being his commanders at the medical centers. So,

if you were a flag officer select, Koenig thought that that was fine to be running Bethesda or Portsmouth or San Diego. And remember, Koenig had also been the CO at San Diego, and was a San Diego guy, so that's what was penciled in.

Admiral Koenig was in his third year, as I recall. Admiral Koenig did not have a fourth year. At the time that was unusual-Hagen had had four and Zimble had had four. When it came time to actually put together the next year's flag slate, it was now Nelson's decision rather than Koenig's. And Nelson decided—at least that's what he told me—that he favored having more experienced flag officers command the medical centers. Therefore, I won't be going there. In fact, he was sending Al Diaz, so that was his decision.

When I got selected, I got sent to what, I think, perhaps in his mind, was not a very good billet with the Marines, which for me, please throw me in that position.

So anyway, I got sent to the TMO job. Now, there's another back story to that because General Krulak[92] was very tight with the CNO, Vern Clark[93]. And Vern Clark was the final decision maker for all Navy flag positions. So, the commandant and the CNO had a close relationship at the time the TMO's job came open. So, it was a combination of Dick Nelson wanting to get me as far out of the Navy as he could, but also the CNO and the Commandant were in excellent communication with each other. And so, I got the TMO job.

Al Diaz had been, I think, decent, but when I got over there it was a very quick turnover. I went over on a Friday; Al was leaving on Friday and I was to take over on

[92] Gen. Victor Krulak, USMC, Commandant of the Marine Corps, 1995 to 1999
[93] Adm. Vern Clark, USN, Chief of Naval Operations, 2000 to 2005.

Monday. My one-year tour at the Pentagon was up on that Sunday, which meant I could permanently keep my Pentagon badge (you had to serve in the Pentagon position for a year before you could keep that Pentagon emblem on your uniform forever).

But any rate, I went over on Friday and Al took me over to the Assistant Commandant's Office. We chatted for about five or ten minutes. He was talking to me and Al was just sitting there. We're done and Al says, "Is there anything that you'd like me to tell you about, Jim?"

He said, "No. We've reviewed his record. We know more about him than his wife does. He'll be just fine." That was that.

When I went in there, they had already thoroughly vetted me. They cleared me through my background through all the time I spent with the Marines in my career. He says, "It's not only fine, it's more than fine." And remember the person who ran the Croatian mission was—wait for it—Jim Jones, the brigadier general at UCOMM. So, the Marines had no difficulty vetting me within Navy circles or Marines circles, and that was that. So, the TMO job for me couldn't have been a better job. It wasn't that I wouldn't have minded going to San Diego. It was my home, but geez, TMO was a dream job.

I know Ridenour described the job as really being the "Surgeon General for the Marine Corps." What do you think about that?

Absolutely correct. The only way that it doesn't work out that way is to get a TMO who doesn't get it, doesn't understand the relationship that should be between the TMO and the Marine Corps-assuming you meet the Marine Corps standards and nobody should be put into that job who doesn't; although, the Navy has done that sometimes.

Zimble was a former TMO. Sometimes the TMO has been a little on the portly side with respect to the Navy standards. Ridenour clearly wasn't. I wasn't. Hell, when I realized I was going to be a TMO I lost ten pounds to make sure I was well under requirement. And you are the only medical flag officer who's authorized to wear Marine Corps uniforms. So, when you were in Marine Corps rags you wore Alpha, Bravo, Charlie uniforms. The only time you don't is at a more formal functions, in which the Marine Corps in their dress uniforms, which you're not authorized to wear, and then you have to wear the Navy equivalent. But I was in Marine Corps regs 95 percent of the time. And when I went over to BUMED for meetings, I had my Marine Corps uniform on.

So, the Marines see you as one of their own, like no other-the Surgeon General may have three stars, but he's not their guy. The TMO is their guy; he's the one who's wearing their uniform; he's the one who reports directly to the ACMC,[94] nobody else. The chain of command is extremely short. There's nobody between you and the ACMC and the Commandant; that's who you work for. And all the Marines know that, and it's a level of influence that I think is unparalleled. And you have to know how to ride it out. I think it's something that Nelson eventually became aware of during his time as Surgeon General. He began to understand the relationship, and realized that he did not put me in a way station in which I would disappear from sight. He tried to do this once again when I got my second-star. When my TMO tour was over in three years Nelson detailed me to go to PACOM, which you can figure out geographically was as far away from

[94] ACMC (Assistant Commandant of the Marine Corps)

Washington or any Medical Department flag billet, that's as far away as you could get. And in fact, Susan and I went out there and we looked at housing and, in fact, published that. He told everybody next year he's going to PACOM. There was just one small problem with that—he hadn't cleared it with the CNO.

The CNO brought me over and talked to me. In fact, it was the year they were deciding who the next SG replacement would be. And Vern Clark brought me over to his quarters on Saturday morning and I sat in his kitchen for two hours and he talked to me about what I was doing and everything that was going on, what I thought about the direction Navy Medicine should be going and what I thought about this and that. It was a very intimate conversation. And why did I have that conversation? I was called by the flag detailer who said on a Thursday, "Saturday morning, you need to be in CNO's quarters in your blues. He wants to talk to you."

That was your SG interview?

That was probably an SG interview, which Vern Clark asked me what I thought about the people who were presumably on the short list being Al Diaz, Mike Cowan, etc., and I gave my opinion, and he asked me where I thought I should go after leaving the TMO, I said, "I think I should go wherever you want me to go, sir."

He said, "You could go anywhere." I could go to any opportunity that was presented and do my best, which was true, it's just me. He said, "Well, I think you should go to San Diego and be the commander there."

I said, "But I'm detailed to go to PACOM."

He said, “I’m the detailer. Nobody’s detailed until I sign their detail. Dick Nelson needs to know that.” He left for leave and I left, and from that point on I was going to San Diego, not PACOM.

[END OF SESSION]